

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05073

5113

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE M aryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Fruitland		LENGTH OF STAY (in this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Fruitland				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED (Type or Print) Henry Kellam Anderson				4. DATE OF DEATH (Month) (Day) (Year) 5 - 5 - 19 55			
5. SEX Male	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH About 1872	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Fruitland, Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Anderson				14. MOTHER'S MAIDEN NAME Sarah Jane Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Eula Deal, Fruitland, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH Indefinite			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma of urinary Bladder				Indefinite			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 20 Oct, 19 54, to 5 May, 1955, that I last saw the deceased alive on 5 May, 19 55, and that death occurred at 10:25 M, from the causes and on the date stated above.							
SIGNATURE E.A. Purnell		DATE THEREOF 5-8-55		NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		LOCATION (City, town, or county) Fruitland, Wicomico Co. Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR May 16, 1955		REGISTRAR'S SIGNATURE Mary W. Hollaway B.N.		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart	
				ADDRESS (Street, city, town, state) 652 W main ST., Salisbury, Md.		DATE SIGNED 9 May 1955	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5114
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05074
 Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Hebron</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Hebron</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marvel Package Co.</u>				STREET ADDRESS (If rural, give location) <u>East XXXXXXXX Church St.</u>			
3. NAME OF DECEASED: (First) <u>FRANK</u>		(Middle) <u>THOMAS</u>		(Last) <u>BAILEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 9 th 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>April 28, 1878</u>		9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer at Marvel Package Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>R.D. Wicomico Co. (Mardela.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Theo. Thomas Bailey</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Elizabeth Bennett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Norma Lea Culp Fruitland Md</u>			
18. MEDICAL CERTIFICATION <u>Moore Ave.</u>						INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>May 9 1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hebron Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hebron Maryland</u>	
DATE REC'D BY LOCAL REG <u>5-10-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

RECEIVED

MAY 13 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Royer, Earl

5068

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05075
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Wicomico		STATE		Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Salisbury		COUNTY		Wicomico	
12 TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		Pittsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
Pen. Gen. Hospital				R.D. #			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		CHARLES		FRANCIS		BAKER	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
MAY		12		19		55	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
Male		White		Married		Sept. 13, 1901	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
53 yrs.		Months 9 Days 29		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Employee of Local Feed Mill				Pittsville, Maryland		Pittsville, Maryland	
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Charles Baker				Kate C. Lewis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS:			
				Mrs. Flora M. Baker (Wife) Pittsville, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
916.0 Immediate cause (a) DUE TO						2 days	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO						14 days	
3rd ° burns 60% Body surface.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
				Home		Pittsville Wicomico Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
4 29 55 P.M.						hit cigarette ignited bed	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				M. D.			
Earl Royer				May 13 1955			
23. BURIAL, CREMATION, REMOVAL (Specify):				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial				May 14, 1955		Farlow Cemetery	
24. FUNERAL DIRECTOR				ADDRESS			
HOLLOWAY & COMPANY				SALISBURY MARYLAND			
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE			
5-16-55				Mary M. Holloway			

BUREAU V. S.

MAY 18 1955

RECEIVED

1 INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

569

CERTIFICATE OF DEATH

05076

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury		LENGTH OF STAY (In this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 At home - 720 Lake Street				STREET ADDRESS (If rural give location) 720 Lake Street			
3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Evelyn (Last) Birckhead				4. DATE OF DEATH (Month) (Day) (Year) 5 - 23 - 1955			
5. SEX Female	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH About 1885	9. AGE last birthday About 70 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Hotel - Inn		11. BIRTHPLACE (State or foreign country) Salisbury, Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Henry West				14. MOTHER'S MAIDEN NAME Hettie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) 3 No		16. SOCIAL SECURITY NO. No 265-03-8665		17. INFORMANT & ADDRESS 720 Lake Street Mrs. Goldie Stout Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 44-2X IMMEDIATE CAUSE (A) <u>Uremia</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH Weeks			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic cardio-vascular</u> (C) <u>renal disease</u>				Years - 1			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. -							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/1/55 to 5/8/55 , 19 55 , that I last saw the deceased alive on 5/8/55 , 19 55 , and that death occurred at 3 p. M. from the causes and on the date stated above. SIGNATURE [Signature] ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-26-55		NAME OF CEMETERY OR CREMATORY Houston Cemetery		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR DATE May 26, 1955		REGISTRAR'S SIGNATURE Mary H. Hallways		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart		ADDRESS 374 E. Church St. Salisbury, Maryland	

0.11 to 0.06.

4-9-72 FBI CCF

At home - 730 Lake Street

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of 2000.

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George Henry West

17. 11. 1940

22-29-30-31-32

02

BUREAU V. S.

MAY 26 1955

RECEIVED

1990-1991

20-25-3

Date: _____

3. *Salmonella typhimurium* DT104

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Wicomico

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN SALISBURYLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS82 PENINSULA GENERAL Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY SOMERSET

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN PRINCESS ANNE

19X-2

STREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Georgia V. Bounds

4. DATE (Month) (Day) (Year)

OF
DEATH:MAY 15 1955

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired)10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If yes, give war or dates
of service)

16. SOCIAL SECURITY No.

17. INFORMATION & ADDRESS:

Mr. Edward Bounds Harbor Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

(A) Coronary OcclusionINTERVAL BETWEEN
ONSET AND DEATH

10 min

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.(B) Arteriosclerotic Heart disease

10 YEARS

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While ☐ Not while ☐
at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APRIL, 1955, to MAY, 1955, that I last saw the deceasedalive on MAY 14, 1955, and that death occurred at 7:10 A M, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

Alberta Mattax

M. D.

5-15-5523. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

BurialMay 17, 1955Grace CemeterySt. Vernon Md5-16-55Therese W. HollowayLevin B. Wilson Princess Anne, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5115

CERTIFICATE OF DEATH

05078

332

Dr. Lewis

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Willards</u>				OR TOWN <u>Willards</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>at Home</u>				<u>at Home (Main Street)</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u> (Middle) <u>CELIA</u> (Last) <u>BRITTINGHAM</u>				(Month) <u>MAY</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Jan 30, 1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>House Work</u>			<u>At Home</u>		<u>near Pocomoke Md</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joel Reynox</u>				<u>Rosina Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk</u>				<u>Mrs. Louise B. Taylor (Daughter) XXX</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>Willards, Maryland</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>48 hours.</u> <u>2 to 5 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>—</u>		<u>—</u>					
21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 13</u> , 19 <u>55</u> , to <u>May 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>55</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank P. Lins</u>				DATE SIGNED <u>May 18 1955</u>			
ADDRESS <u>Willards, Maryland</u>				LOCATION (City, town, or county) <u>Near Willards, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>May 18, 1955</u>		<u>Dennis Cemetery</u>		<u>Near Willards, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>May 20, 1955</u>		<u>Mary H. Holloway</u>		<u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>			

CERTIFICATE OF DEATH

2112

Reg. Dist. No.

1. NAME OF DECEASED (PRINT OR TYPE)

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF STATE

21. SIGNATURE OF COUNTY

22. SIGNATURE OF CITY

23. SIGNATURE OF TOWNSHIP

24. SIGNATURE OF PARISH

25. SIGNATURE OF VILLAGE

26. SIGNATURE OF HAMLET

27. SIGNATURE OF CENSUS TRACT

28. SIGNATURE OF BLOCK

29. SIGNATURE OF HOUSEHOLD

30. SIGNATURE OF ROOM

31. SIGNATURE OF BED

32. SIGNATURE OF CHAIR

33. SIGNATURE OF TABLE

34. SIGNATURE OF CUPBOARD

35. SIGNATURE OF DRAWER

36. SIGNATURE OF DOOR

37. SIGNATURE OF WINDOW

38. SIGNATURE OF FLOOR

39. SIGNATURE OF CEILING

40. SIGNATURE OF WALL

41. SIGNATURE OF ROOF

42. SIGNATURE OF GROUND

43. SIGNATURE OF AIR

44. SIGNATURE OF WATER

45. SIGNATURE OF FIRE

46. SIGNATURE OF LIGHT

47. SIGNATURE OF SOUND

48. SIGNATURE OF SMELL

49. SIGNATURE OF TASTE

50. SIGNATURE OF TOUCH

51. SIGNATURE OF FEEL

52. SIGNATURE OF THINK

53. SIGNATURE OF KNOW

54. SIGNATURE OF BELIEVE

55. SIGNATURE OF LOVE

56. SIGNATURE OF HATE

57. SIGNATURE OF DESIRE

58. SIGNATURE OF AVOID

59. SIGNATURE OF SEEK

60. SIGNATURE OF FIND

61. SIGNATURE OF LOSE

62. SIGNATURE OF WIN

63. SIGNATURE OF FAIL

64. SIGNATURE OF SUCCEED

65. SIGNATURE OF START

66. SIGNATURE OF STOP

67. SIGNATURE OF GO

68. SIGNATURE OF COME

69. SIGNATURE OF LEAVE

70. SIGNATURE OF STAY

71. SIGNATURE OF ENTER

72. SIGNATURE OF EXIT

73. SIGNATURE OF ARRIVE

74. SIGNATURE OF DEPART

75. SIGNATURE OF BEGIN

76. SIGNATURE OF END

77. SIGNATURE OF START

78. SIGNATURE OF STOP

79. SIGNATURE OF GO

80. SIGNATURE OF COME

81. SIGNATURE OF LEAVE

82. SIGNATURE OF STAY

83. SIGNATURE OF ENTER

84. SIGNATURE OF EXIT

85. SIGNATURE OF ARRIVE

86. SIGNATURE OF DEPART

87. SIGNATURE OF BEGIN

88. SIGNATURE OF END

89. SIGNATURE OF START

90. SIGNATURE OF STOP

91. SIGNATURE OF GO

92. SIGNATURE OF COME

93. SIGNATURE OF LEAVE

94. SIGNATURE OF STAY

95. SIGNATURE OF ENTER

96. SIGNATURE OF EXIT

97. SIGNATURE OF ARRIVE

98. SIGNATURE OF DEPART

99. SIGNATURE OF BEGIN

100. SIGNATURE OF END

BUREAU V. 1

MAY 20 1955

RECEIVED

DEPT. OF HEALTH

ATLANTA, GA. MAY 20 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55-20M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5116

CERTIFICATE OF DEATH

Reg. Dist. No. 232

05079

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Wetipquin		LENGTH OF STAY (in this place) All of life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wetipquin		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 At home - Wetipquin				STREET ADDRESS (If rural give location) Quantico, Route # 1		/	
3. NAME OF DECEASED (First) Ella (Middle) Mae (Last) Camper				4. DATE OF DEATH (Month) 5 (Day) 6 (Year) 19 55			
5. SEX Female	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 11-2-1910	9. AGE last birthday 44 yrs.	IF UNDER 1 YEAR Months 6 Days 4	IF UNDER 24 HRS. Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10b. KIND OF BUSINESS OR INDUSTRY Chicken Plant		11. BIRTHPLACE (State or foreign country) Wetipquin, Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Wright				14. MOTHER'S MAIDEN NAME Elizabeth Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 219-07-6359		17. INFORMANT & ADDRESS Marcellus Camper, Quantico, Md. Rt. #1			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) Carcinomatous						1 year	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma Breast						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Infection						6 mo.	
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 5/6		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/1/6, 1950, to 5/6, 1955, that I last saw the deceased alive on 5/6, 1955, and that death occurred at 3:45 PM, from the causes and on the date stated above.							
SIGNATURE Richard H. Saunders				ADDRESS (Street, city, town, state) Quantico, Md.		DATE SIGNED 5/17/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-9-55		NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		LOCATION (City, town, or county) Wetipquin, Wicomico Co. Md.	
24. REC'D BY REGISTRAR DATE May 11, 1955		REGISTRAR'S SIGNATURE Mary W. Hollman R.N.		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart		ADDRESS 324 E. Church St. Salisbury, Md.	

CERTIFICATE OF DEATH

1. NAME OF DECEASED Maryland Westphalia		2. SEX Male		3. AGE 11-3-1910		4. MARRIAGE Married		5. OCCUPATION Cook		6. PLACE OF BIRTH Westphalia, Wisconsin Co. NC.		7. PLACE OF DEATH Westphalia, Wisconsin Co. NC.		8. CAUSE OF DEATH Quarantine, 1918	
9. DATE OF DEATH MAY 11 1918		10. TIME OF DEATH 10:00 AM		11. SIGNATURE OF DECEASED Anthony W. H. H.		12. SIGNATURE OF WITNESSES Maryland, Westphalia, Wisconsin Co. NC.		13. SIGNATURE OF PHYSICIAN Anthony W. H. H.		14. SIGNATURE OF CLERK Maryland, Westphalia, Wisconsin Co. NC.		15. SIGNATURE OF JURY Maryland, Westphalia, Wisconsin Co. NC.		16. SIGNATURE OF JUDGE Maryland, Westphalia, Wisconsin Co. NC.	

BUREAU V. S.

MAY 11 1918

RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5117 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 950801

No. 336

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Delaware		COUNTY Sussex	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Delmar 46X-3			
TOWN Parsonburg Md.				STREET ADDRESS 8 Delaware Avenue			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00							
3. NAME OF DECEASED:		(First) Byard		(Middle) Jason		(Last) Carey	
(Type or Print)				4. DATE OF DEATH		(Month) May (Day) 19 (Year) 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE MARRIED, WIDOWED MARRIED	8. DATE OF BIRTH: 9-3-1915		9. AGE last birthday: 39 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Operator		10b. KIND OF BUSINESS OR INDUSTRY: Feed Mill		11. BIRTHPLACE (State or foreign country): Delmar, Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Carey				14. MOTHER'S MAIDEN NAME: Helen May Phillips			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes		(If Yes, give war or dates of service) WW #2		16. SOCIAL SECURITY No.: 222-05-6290		17. INFORMANT & ADDRESS: Caraleigh Carey, Delmar, Delaware	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						Sudden	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE [Signature]		M. D. [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED 5-20-55	
23. BURIAL, removal (Specify): Burial		DATE THEREOF 5-22-55		NAME OF CEMETERY OR CREMATORIUM Mt Olive		LOCATION (City, town, or county) (State) Delmar, Delaware	
DATE REC'D BY LOCAL REG. May 20, 1955		REGISTRAR'S SIGNATURE [Signature]		FUNERAL DIRECTOR [Signature]		ADDRESS [Signature]	

BUREAU V. S.

MAY 23 1955

RECEIVED

Carl H. Royen

05081

5118

CERTIFICATE OF DEATH

Reg. Dist. No. 332

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH					2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY <u>Wicomico</u>		MARYLAND			STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town)				
X TOWN <u>Pantioke</u>		<u>Lifetime</u>			TOWN <u>Pantioke</u>		X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS					STREET ADDRESS (If rural give location)		1		
3. NAME OF DECEASED (Type or Print)					4. DATE OF DEATH				
(First) <u>Nina</u> (Middle) <u>E. Catlin</u> (Last)					(Month) <u>5</u> (Day) <u>31</u> (Year) <u>1955</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>12-29-1875</u>		9. AGE last birthday <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pantioke, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>	
13. FATHER'S NAME <u>William Cox</u>		14. MOTHER'S MAIDEN NAME <u>Hester Lexington</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Edward Catlin, Pantioke, Maryland</u>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					4 day				
585X IMMEDIATE CAUSE (A) <u>Peritonitis</u>					1 week				
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Cholecystitis</u>									
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart Disease</u>					10 years				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>27 Sept</u> , 19 <u>47</u> , to <u>31 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>31 May</u> , 19 <u>55</u> , and that death occurred at <u>8:45 A.M.</u> , from the causes and on the date stated above.									
SIGNATURE <u>Richard H. Saunders</u> M.D.					ADDRESS (Street, city, town, state) <u>Pantioke Md</u>			DATE SIGNED <u>6/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>6/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Turner's Cemetery</u>		LOCATION (City, town, or county) <u>Pantioke, Maryland</u>		(State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>B. J. Bayles</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Emeline H. Wessell</u>		ADDRESS <u>Pantioke, Maryland</u>			
DATE <u>June 2, 1955</u>		<u>John Holman</u>							

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05082
Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>12</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>402 Hastings St</u>				STREET ADDRESS (If rural, give location) <u>402 Hastings St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BABY BOB CODY</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>May 4 th 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Still born</u>	8. DATE OF BIRTH:		9. AGE last birthday: yrs. <u>0</u> Months <u>0</u> Days <u>0</u>		IF UNDER 1 YEAR Hours <u>0</u> Min. <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>402 Hastings St Salisbury</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Unk</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Jennett Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Bessie Jones (Grandmother) 402 Hastings St. Salisbury, Maryland</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION			
<u>776X</u> Immediate cause (a) <u>Prematurity</u> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>			
Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Earl L. Boyer</u>		M. D. <u>May 5 1955</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 5, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5-6-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

1055283211

RECEIVED

MAY 11 1965

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05083

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		7 hours		TOWN <u>Cambridge</u>		09X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
91 <u>Deer's Head State Hospital</u>				Route # 2 ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LIZZIE</u>		(Middle) <u>A.</u>		(Last) <u>CORSEY</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>3/2/1865</u>	
9. AGE last birthday <u>90</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
-- --		-- --		<u>Annapolis, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wheatley Applegarth</u>				<u>Emily North</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Unk. 9</u> (If Yes, give war or dates of service)				-- --		<u>Hospital Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Acute myocardial insufficiency</u>						<u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerotic heart disease</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Nephrosclerosis</u>						<u>unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
-- --		-- --		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
-- --		M.		-- --			
22. I hereby certify that I attended the deceased from <u>May 23, 1955</u> , to <u>May 23, 1955</u> , that I last saw the deceased alive on <u>May 23, 1955</u> , and that death occurred at <u>5:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Malden, M.D.</u>				DATE SIGNED <u>5/24/55</u>			
ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital, Salisbury, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-25-1955</u>		<u>Greenlawn Cemetery</u>		<u>Cambridge, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>5-27-55</u>		<u>Mary W. Holloman</u>		<u>LeCompte Funeral Service</u>		<u>Cambridge, Maryland</u>	

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05084

337

Dr. C. Hearsh

5073

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>3 DAYS</u>		TOWN <u>SALISBURY</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>RT # 4</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>MARGARET</u> (Middle) <u>JANE</u> (Last) <u>COULBOURNE</u>				<u>MAY</u> <u>1</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>Divorced</u>	<u>Jan. 16, 1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Work</u>		<u>At Home</u>		<u>Wicomico Co. Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>George William Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Tilghman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Mr. Preston Norris Mitchell 618 W. Main St</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Salisbury, Maryland</u>		INTERVAL BETWEEN ONSET AND DEATH	
<u>584X</u> IMMEDIATE CAUSE (A) <u>Subphrenic Abscess, Localized</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Peritonitis due to gangrenous</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Ischemic gall bladder, filled with stones.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 28, 1955</u> to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>May 1, 1955</u> , and that death occurred at <u>11:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. C. Hearsh</u>				ADDRESS (Street, city, town, state) <u>M.D. West Church St Salisbury, Maryland</u>			
DATE <u>5/3/55</u>				DATE SIGNED <u>May 2, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 4th 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mitchell, Cemetery</u>		LOCATION (City, town, or county) (State) <u>Snow Hill Rd. Near Salisbury</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 15085

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Salisbury</u> <u>12</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural, give location) <u>317 S. Division St</u> <u>1</u>			
3. NAME OF DECEASED: (First) <u>LAIRD</u>		(Middle) <u>JAMES</u>		(Last) <u>DAVIS</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>13</u> (Year) <u>th</u> <u>19</u> <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 19, 1877</u>	9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR: Months <u>7</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Clerk - Farmers & Planters Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Salisbury, Maryland</u>		11. BIRTHPLACE (State or foreign country): <u>USA</u>		
13. FATHER'S NAME: <u>Joseph E. Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Sallie Gray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Georgie Davis (Wife) 317 S. Division St.</u>		
18. MEDICAL CERTIFICATION <u>Salisbury, Maryland</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Fracture of skull & intra cranial hemorrhage</u>							
Antecedent cause(s) (b) <u>hemorrhage</u>							
Diseases or conditions, if any, giving rise to the above cause (c) <u>stating underlying cause last</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Wachman</u>		21c. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>MD</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>5</u> <u>13</u> <u>55</u> <u>9A</u> M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from platform struck head</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl E. Boyer</u>		M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 14 1955</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>May 15, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State): <u>Salisbury, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5-16-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR ADDRESS: <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>			

BUREAU V. S.

MAY 18 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5119 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 05086
No. 132

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Parsonsburg</u>				TOWN <u>Parsonsburg</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. # 2</u>				STREET ADDRESS (If rural, give location) <u>R.D. # 2</u>			
3. NAME OF DECEASED: (Type or Print) <u>Joshua Jr in Downes</u>				4. DATE OF DEATH <u>May 8 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct. 13, 1906</u>	
9. AGE last birthday: <u>48</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>R.D. Parsonsburg Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>			
13. FATHER'S NAME: <u>Unk</u>				14. MOTHER'S MAIDEN NAME: <u>Unk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>9</u>		17. INFORMANT & ADDRESS: <u>Mrs. Stella Downs (Wife) R.D. # 2 Parsonsburg Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>976X</u> Immediate cause (a) <u>gunshot wound of head</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>6</u>				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>home</u>		21c. (City or town) _____ (County) _____		21d. (State) _____	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Kendrick M. Callaway</u>		M. D. <u>May 8 1955</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 8 1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Line Church Cemetery</u>		LOCATION (City, town, or county) <u>R.D. # Parsonsburg, Maryland</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>5-10-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

RECEIVED

MAY 13 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05087

5075

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>SALISBURY</u>		27 Days.		BERLIN		23 X 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
822 PENINSULA GENERAL HOSPITAL				227 S. MAIN ST.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
ETHEL ELIZABETH FISHER				DATE OF DEATH: May 27 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	WHITE		MAY 5, 1894	61 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Home		Berlin Md RFD		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
CHARLES E. FISHER				EVA HOLLO VVAY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
4 no		no		Mr. Edward Fisher Berlin Md			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.0 IMMEDIATE CAUSE				Myocardial Insufficiency Unknown			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) Arteriosclerotic Heart Disease			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
Anemia							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 11:54 P.M. from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
David J. Schure				Salisbury Md.		May 28, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6/1/55		Evergreen		Berlin Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6-1-55		Mary W. Holloray		Dennis A. Burbage		Berlin Md	

BUREAU V. S.

JUN 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05088

5076

Item 7 Film 182 6-14-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Berlin</u>		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)		✓	
3. NAME OF DECEASED: (First) <u>George</u> (Middle) <u>B.</u> (Last) <u>Gray</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 31 - 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>		8. DATE OF BIRTH: <u>May 3, 1872</u>	
9. AGE last birthday: <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own farm</u>		11. BIRTHPLACE (State or foreign country): <u>Berlin Md R.D.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u> Jesse Gray</u>			
14. MOTHER'S MAIDEN NAME: <u>Jane Bassett</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service): <u>WW</u>			
16. SOCIAL SECURITY NO. <u>W.</u>				17. INFORMANT & ADDRESS: <u>Mr. Wm Thompson Berlin Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.							
IMMEDIATE CAUSE (A) <u>Strain + generalized Cachexia</u>						4 days	
ANTECEDENT CAUSE (S) DUE TO <u>due to Emphysema & Atherosclerosis</u>						2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerosis</u>							
(C) <u>Coronary of Left Cor.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-30</u> , 1955, to <u>5/31</u> , 1955, that I last saw the deceased alive on <u>5/31</u> , 1955, and that death occurred at <u>7:43</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Wm R. Maffei</u>				ADDRESS <u>M.D. Salisbury, Md.</u>		DATE SIGNED <u>6-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/3/54</u>		<u>Evergreen</u>		<u>Berlin Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-4-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Anna A. Burban</u>		ADDRESS <u>Berlin Md</u>	

BUREAU V. S.

JUN 8 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5077

CERTIFICATE OF DEATH

05089

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		LENGTH OF STAY (in this place) 11 yrs.		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Ocean City B lvd.				STREET ADDRESS (If rural give location) Ocean City Blvd.			
3. NAME OF DECEASED (Type or Print) ANNIE COX HARDY				4. DATE OF DEATH 5/14/1955			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH March 18, 1871	
9. AGE last birthday 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Richard Cox				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS J. H. Hardy Same	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4222 IMMEDIATE CAUSE (A) congestive heart failure				2 week			
ANTECEDENT CAUSE(S) DUE TO (B) degenerative heart disease				2 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb , 19 54 , to May 14 , 19 55 , that I last saw the deceased alive on May 13 , 19 55 , and that death occurred at 7:45 P M, from the causes and on the date stated above.							
SIGNATURE J. H. Hardy				ADDRESS (Street, city, town, state) Salisbury Md.		DATE SIGNED 5/16/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) B urial		DATE THEREOF 5/17/1955		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE May 18, 1955		REGISTRAR'S SIGNATURE Mary T. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Md.			

CERTIFICATE OF DEATH

DECEASED Name: WILLIAM Age: 11 Sex: MALE Race: WHITE Date of Birth: 1944 Date of Death: 1955 Place of Birth: GREEN GLASS BLVD. Cause of Death: UNION Manner of Death: UNION Signature: J. H. HARRY Title: DR. Date: 1955		PLACE OF DEATH Name: WILLIAM Age: 11 Sex: MALE Race: WHITE Date of Birth: 1944 Date of Death: 1955 Place of Birth: GREEN GLASS BLVD. Cause of Death: UNION Manner of Death: UNION Signature: J. H. HARRY Title: DR. Date: 1955	
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BUREAU V. S.

MAY 18 1955

RECEIVED

THE WILL & JOHNSON CO. BALTIMORE, MD.
 1955
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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5120

CERTIFICATE OF DEATH

05090

Dr. Lewis

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Parsonsburg				TOWN Parsonsburg		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Bryan Nursing Home				STREET ADDRESS (If rural give location) R.D. # 2 Salisbury, Md.			
3. NAME OF DECEASED (First) ETHEL (Middle) M (Last) HARRINGTON				4. DATE OF DEATH (Month) May (Day) 4 (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 27, 1882	9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months 10 Days 7	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Bialve Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Unk) Jackson				14. MOTHER'S MAIDEN NAME Unk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. J. Alton Harrington (Son) 826 S. Division St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) Chronic myocarditis				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Rheumatoid arthritis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-15, 1955, to 5-2, 1955, that I last saw the deceased alive on 5-2, 1955, and that death occurred at 8:00A.M. from the causes and on the date stated above.							
SIGNATURE Frank Lewis				DATE SIGNED May 6 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				ADDRESS (Street, city, town, state) M.D. Willards, Maryland			
DATE THEREOF May 6, 1955		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) Salisbury, Maryland		(State)	
24. REC'D BY REGISTRAR May 9, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			
				ADDRESS SALISBURY MARYLAND			

CERTIFICATE OF DEATH

2150

FILE NO. 100

1. NAME OF DECEASED (Print Name)

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF CLERK

22. SIGNATURE OF ASSISTANT CLERK

23. SIGNATURE OF RECEPTIONIST

24. SIGNATURE OF TELEPHONE OPERATOR

25. SIGNATURE OF MAIL ROOM

26. SIGNATURE OF RECORDS SECTION

27. SIGNATURE OF IDENTIFICATION SECTION

28. SIGNATURE OF LABORATORY

29. SIGNATURE OF RADIOLOGY

30. SIGNATURE OF PATHOLOGY

31. SIGNATURE OF ANATOMY

32. SIGNATURE OF HISTOLOGY

33. SIGNATURE OF MICROBIOLOGY

34. SIGNATURE OF IMMUNOLOGY

35. SIGNATURE OF EPIDEMIOLOGY

36. SIGNATURE OF PREVENTIVE MEDICINE

37. SIGNATURE OF PUBLIC HEALTH

38. SIGNATURE OF COMMUNITY MEDICINE

39. SIGNATURE OF BEHAVIORAL SCIENCE

40. SIGNATURE OF HEALTH SERVICES ADMINISTRATION

41. SIGNATURE OF HEALTH POLICY

42. SIGNATURE OF HEALTH ECONOMICS

43. SIGNATURE OF HEALTH LAW

44. SIGNATURE OF HEALTH ETHICS

45. SIGNATURE OF HEALTH CARE DELIVERY

46. SIGNATURE OF HEALTH CARE RESEARCH

47. SIGNATURE OF HEALTH CARE EVALUATION

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243. SIGNATURE OF HEALTH CARE PROMOTION

244. SIGNATURE OF HEALTH CARE RESEARCH

245. SIGNATURE OF HEALTH CARE EVALUATION

246. SIGNATURE OF HEALTH CARE IMPROVEMENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5070
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

05091
 Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
12 TOWN <u>Schubert</u>		<u>18 days</u>		TOWN <u>Berlin</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
<u>Ransie Walker Hastings</u>				<u>May 25 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
			<u>March 11-1903</u>	<u>52</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Const guard</u>		<u>Berlin Md</u>		<u>USA</u>	
13. FATHER'S NAME: <u>John Henry Hastings</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ellen Timmons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>✓</u>		<u>Mrs Culver Baker (Sister) R28,</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
824X Immediate cause <u>Broncho Pneumonia - with edema lung</u>				<u>10 days</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last				<u>Broken neck</u>			
(c) <u>due to auto accident</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Long standing heart 2nd Blod Mt</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>2</u>				<u>2</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)		21c. (City or town) (County)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
CAUSE OF DEATH.		<u>Home</u>		<u>Near Berlin Worcester Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 15-4:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Ditched his car when he had a "break"</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>M. D. Timmons</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/25/55</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/27/55</u>		<u>Buckingham</u>		<u>Berlin Md</u>	
DATE REC'D BY LOCAL REG. <u>5/31/55</u>		REGISTRAR'S SIGNATURE <u>Mary G. Holloway</u>		24. FUNERAL DIRECTOR <u>James A. Buckner</u>		ADDRESS <u>Berlin Md</u>	

RECEIVED

MAY 31 1955

BUREAU V. 3

1

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05092

5079

CERTIFICATE OF DEATH

Dr. Lee Lawry

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY OR TOWN Rural Salisbury		LENGTH OF STAY (in this place)		CITY OR TOWN Rural Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 1 (Near Fruitland)		STREET ADDRESS R.D. # 1 (Near Fruitland)					
3. NAME OF DECEASED (Type or Print) ELNORA		(First) NITCH		(Last)		4. DATE OF DEATH MAY 25 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 30, 1875	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months 6 Days 25		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own home		11. BIRTHPLACE (State or foreign country) Worcester County Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Hooper Mc Grath				14. MOTHER'S MAIDEN NAME Lidia Annie Pusey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Thomas M. Hitch (Husband) R.D. # 1 Salisbury, Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 yrs			
IMMEDIATE CAUSE (A) Central Nervous System							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 8:00 A.M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1946 , 19 55 , to 1955 , 19 55 , that I last saw the deceased alive on May 25, 1955 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
SIGNATURE Lee Lawry				ADDRESS (Street, city, town, state) Fruitland, Maryland		DATE SIGNED May 26 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27, 1955		NAME OF CEMETERY OR CREMATORY Zion Cemetery		LOCATION (City, town, or county) R.D. # 1 Salisbury, Md. - Fruitland	
24. RECEIVED BY REGISTRAR May 31, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Dr. J. Lee Janny

Physician

Witness

James H. Janny

R. L. V. I. (New York)

Witness

James H. Janny

R. L. V. I. (New York)

Witness

James H. Janny

Witness

October 30, 1975

79

2

25

Greenleaf County, Md.

Johnnie Annis Janny

Dr. James H. Janny (Witness) R. L. V. I.

The undersigned, a duly qualified physician, do hereby certify that the above named person died on the day and at the place stated above.

James H. Janny

No.

BUREAU V. 2

MAY 31 1955

RECEIVED

Frederick, Maryland

R. L. V. I. (New York)

May 31, 1955

Witness

WILSON & COMPANY

BALTIMORE, MARYLAND

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05093

5780

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bivalve</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>Bivalve</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>IDA</u> (First) <u>Mae</u> (Middle) <u>HORNER</u> (Last)				4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6-11-1877</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Merchandise Wctry, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dodge Fox bush</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>22 0-32-0886</u>		17. INFORMANT & ADDRESS <u>Bivalve, Maryland</u> <u>Nelson Horner</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Chronic myocarditis - acute failure</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Embolism rt. iliac artery</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myxomatous - auricular fibrillation</u>							
19a. DATE OF OPERATION <u>5-10-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Embolism rt. iliac artery</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19<u>50</u>, to....., 19<u>55</u>, that I last saw the deceased alive on....., 19<u>55</u>, and that death occurred at....., 19<u>55</u>, from the causes and on the date stated above.							
SIGNATURE <u>Phyllis J. J...</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>5-12-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>5-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bivalve Cemetery</u>		LOCATION (City, town, or county) (State) <u>BIVALVE, Md.</u>	
24. KEPT BY REGISTRAR <u>May 16, 1955</u>		REGISTRAR'S SIGNATURE <u>May 11, Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Hersh...</u>		ADDRESS <u>Bivalve, Md.</u>	

CERTIFICATE OF DEATH

Rev. Date, 1955

1. Name of deceased (Print or write)

2. Sex

3. Place of death

4. Age

5. Date of death

6. Cause of death

7. Day of death

8. Month of death

9. Year of death

10. Time of death

11. Place of death

12. Name of physician

13. Name of hospital

14. Name of funeral home

15. Name of undertaker

16. Name of cemetery

17. Name of burial place

18. Name of interment

19. Name of cremation

20. Name of disposition

21. Name of disposition

22. Name of disposition

23. Name of disposition

24. Name of disposition

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50. Name of disposition

BUREAU V. S.

MAY 16 1955

RECEIVED

INVESTIGATION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05094

5081

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		LENGTH OF STAY (in this place) <u>1 yr. 9½ mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Maryland</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>		STREET ADDRESS (If rural give location) <u>Route #2</u>					
3. NAME OF DECEASED (First) (Middle) (Last) <u>James Lester Hudson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 4 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Marries</u>	8. DATE OF BIRTH <u>June 18, 1903</u>	9. AGE last birthday <u>51</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Duncan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease with cardio-</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>megaly</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pyelonephritis - chronic</u>						<u>1½ years</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 17, 1953</u>, to <u>May 4, 1955</u>, that I last saw the deceased alive on <u>May 4, 1955</u>, and that death occurred at <u>8:35A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. J. J. J.</u>		ADDRESS (Street, city, town, state) <u>Deer's Head Hospital, Salisbury, Maryland</u>		DATE SIGNED <u>May 4, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>Taylor's Gate Cemetery</u>		LOCATION (City, town, or county) (State) <u>near Snow Hill, Wor. Co. Md.</u>	
24. REC'D BY REGISTRAR <u>May 6, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u> <u>324 E. Church St. Salisbury, Maryland</u>			

CERTIFICATE OF DEATH

5621

Reg. Dist. No.

1. Usual Residence (Home) of Deceased

2. Date of Death

MARYLAND

3. Date of Death

4. Date of Death

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6. Date of Death

7. Date of Death

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BUREAU V. 3

MAY 6 1955

RECEIVED

12-1-55

12-1-55

PHOTOGRAPHED

NOTED JANUARY 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5982				15095 Reg. Dist.			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 331							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Md.		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
12 TOWN Salisbury		10 days		Pocomoke City 23-42-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen Gen Hosp				STREET ADDRESS (If rural, give location) 930 Second St. ✓			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
ARTHUR		E.		JACKSON			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married		8. DATE OF BIRTH: Nov 28, 1877	
						9. AGE last birthday: 77 yrs.	
						10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Inspector	
						11. BIRTHPLACE (State or foreign country): Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Stephen W. Jackson				14. MOTHER'S MAIDEN NAME: Laura J. Littleton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		(If Yes, give war or dates of service) None		16. SOCIAL SECURITY No.: 717-07-9139		17. INFORMANT & ADDRESS: Elwood F. Jackson, Hampton, Va.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
9023 Immediate cause Pulmonary Embolism							
Antecedent cause(s) Probably due to fracture of femur							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last Due to accident.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Prostatic Surgery							
19a. DATE OF OPERATION: 4/11/55		19b. MAJOR FINDING OF OPERATION: Fracture of femur				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) 22 (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: April 11 1955 P.M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Slipped on a loose brick which rolled into a higher truck with force enough to fracture his hip.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE M. E. Artorius		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED May 4th 55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 5/5/55		NAME OF CEMETERY OR CREMATORY Remson Methodist		LOCATION (City, town, or county) (State) Pocomoke, Md.	
DATE REC'D BY LOCAL REG. 5-5-55		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR Henry H. Watson, Pocomoke, Md.		ADDRESS	

BUREAU V. S.

MAY 9 1955

RECEIVED

5083

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>VIRGINIA</u> COUNTY <u>Accomac</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>SALISBURY</u>		<u>1 wk</u>		<u>HALLWOOD</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82 PENINSULA General Hospital</u>				<u>RT. #1.</u>			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
<u>THOMAS</u>				<u>Jenkins</u>		<u>MAY 14 1955</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>MALE</u>		<u>white</u>				<u>March 20 1869</u>	
9. AGE last birthday		10. AGE last birthday		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>86</u> yrs.		<u>86</u> yrs.		<u>Virginia</u>		<u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Farm owner</u>				<u>Farm</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Jenkins</u>				<u>Mary Cliff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>4 No</u>				<u>None</u>			
17. INFORMANT & ADDRESS:							
<u>Mrs Lee Ayres. Pocomoke, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE							
(A) DUE TO <u>Coronary Artery Thrombosis</u>						<u>5 minutes</u>	
ANTECEDENT CAUSE (S)							
(B) DUE TO <u>Coronary Artery Atherosclerosis</u>						<u>Unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) DUE TO <u>Cerebral Atherosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Uremia</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
20. AUTOPSY?							
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 7, 1955</u> , to <u>May 14, 1955</u> , that I last saw the deceased alive on <u>May 14, 1955</u> , and that death occurred at <u>11:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Henry W. Holloway</u>		<u>Salisbury Ind.</u>		<u>May 15, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>May 16, 1955</u>		<u>May 16, 1955</u>		<u>Downing Cemetery</u>		<u>Oak Hall VA</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-16-55</u>		<u>Mary W. Holloway</u>		<u>Henry W. Holloway</u>		<u>Pocomoke</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 18 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5984

CERTIFICATE OF DEATH

05097

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<u>12</u> TOWN <u>Salisbury, Maryland</u>		<u>4 yr. 1 mo. 18 days</u>		<u>3601-4</u> TOWN <u>Baltimore Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>91</u> <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>1727 Madison Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bessie</u> (Middle) <u>Reed</u> (Last) <u>Johnson</u>				(Month) <u>May</u> (Day) <u>14</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>Sept. 1, 1890</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>unk</u>		<u>unk</u>		<u>Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>unk</u>				<u>unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unk</u>		<u>unk</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>153X</u> IMMEDIATE CAUSE (A) <u>Unoperable Ca. of colon with advanced Metastases</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Hypertensive arteriosclerotic cardiovascular disease</u> <u>Unk ?</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 26, 19 51</u>, to <u>May 14, 19 55</u>, that I last saw the deceased alive on <u>May 14, 19 55</u>, and that death occurred at <u>9:47 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>H. V. Juerman</u>				<u>Salisbury, Maryland</u>		<u>5/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 19, 1955</u>		<u>St. Auburn</u>		<u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 18, 1955</u>		<u>Mary H. Holloway</u>		<u>William J. Holloway</u>		<u>1631 Smith Hill Ave.</u>	

Received of Mr. [illegible] the sum of [illegible] for [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 05098
 Reg. Dist.

 No. 312

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		ST <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>12 TOWN Salisbury</u>		<u>7 weeks</u>		TOWN <u>Westover Anne</u> <u>198-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>96 Spring Hill Sanstarium</u>				<u>R.F.D.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH		5. MONTH (Day) (Year)		6. YEAR	
<u>Ida Tolles Jones</u>		<u>May 27</u>		<u>19</u>		<u>55</u>	
7. SEX:	8. COLOR OR RACE:	9. SINGLE, MARRIED, WIDOWED, DIVORCED,	10. DATE OF BIRTH:	11. AGE last birthday:	12. IF UNDER 1 YEAR	13. IF UNDER 24 HRS.	14. IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>Widowed</u>	<u>March 11, 1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>none</u>		<u>Ludington, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Tolles</u>				<u>Emmeline Neidig</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>no</u>		<u>Mrs Robert McDorman</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Bronchial Pneumonia</u> Antecedent cause(s) (b) <u>Fractured right femur</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Senility</u>						<u>2-3 days</u> <u>15 weeks</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>0</u>				<u>0</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Same</u>)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>Westover R.F.D. Somerset Maryland</u>		<u>Westover R.F.D. Somerset Maryland</u>		<u>Westover R.F.D. Somerset Maryland</u>		<u>May 28-55</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 12-55 11:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall in bed room</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>W. H. Johnson M.D.</u>		<u>M.D.</u>		<u>DEPUTY MEDICAL EXAMINER</u>		<u>May 28-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>May 29, 1955</u>		<u>St. Andrew Cemetery</u>		<u>Princess Anne, Maryland</u>	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-2-55</u>		<u>Mary W. Holloway</u>		<u>Levin B. Wilson</u>		<u>Princess Anne, Maryland</u>	

5985

JUN 6 1955

RECEIVED

5086

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY WICOMICO MARYLANDCITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY LENGTH OF STAY (in this place) 19 Days.HOSPITAL OR INSTITUTION OR STREET ADDRESS PENINSULA GENERAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE VIRGINIA COUNTY ACCOMACCITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 13 Loxom 83X-3STREET ADDRESS (If rural give location) R#1 ✓3. NAME OF DECEASED: (First) (Middle) (Last) LEMUEL Thomas LANKFORD4. DATE (Month) (Day) (Year) OF DEATH: MAY 1 19555. SEX: MALE 6. COLOR OR RACE: WHITE 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Aug 28, 18809. AGE last birthday 74 yrs. 8 Months 3 Days 3 Hours 3 Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Guilford, Va12. CITIZEN OF WHAT COUNTRY? U.S.A.13. FATHER'S NAME: Samuel T. Lankford14. MOTHER'S MAIDEN NAME: Mary E. Justice15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes

16. SOCIAL SECURITY NO.

17. INFORMANT'S ADDRESS: Gva Lankford Bluffs, Va

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE

(A)

DUE TO Cornary thrombosis

ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertrophy prostate.19A. DATE OF OPERATION: 4-18-55-119B. MAJOR FINDINGS OF OPERATION: Benign hypertrophy prostate

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-18-55, 1955, to 5-1-55, 1955 that I last saw the deceasedalive on 5-1-55, 1955, and that death occurred at 7:00 M, from the causes and on the date stated above.SIGNATURE Philip A. Lankford

ADDRESS

DATE SIGNED 5-3-55M. D. Salisbury, Md23. BURIAL, CREMATION, REMOVAL (SPECIFY) BurialDATE THEREOF 5/3/55NAME OF CEMETERY OR CREMATORY LibertyLOCATION (City, town, or county) Parkside(State) Va.DATE REC'D BY LOCAL REGISTRAR 5-3-55REGISTRAR'S SIGNATURE Mary W. Holloway24. FUNERAL DIRECTOR Brutskians & Richard J. HuganADDRESS Parkside, Va

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 6 1955

RECEIVED

May 2/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5121

CERTIFICATE OF DEATH

05100

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY OR TOWN <u>White Haven</u> <u>Lifetime</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY OR TOWN <u>White Haven</u> STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Maxion D. Larmore</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-19-1896</u>
9. AGE last birthday <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>White Haven</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ambrose Larmore</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Robertson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT & ADDRESS <u>Bertha Larmore, 2 White Haven</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 452X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>			<u>1 day</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>			<u>Unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pulmonary Edema</u>			<u>1 day</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/15</u> , 19 <u>55</u> , to <u>5/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/12</u> , 19 <u>55</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>D. H. Saunders</u>		ADDRESS (Street, city, town, state) <u>Nanticoke Md.</u>	
DATE <u>May 16, 1955</u>		DATE SIGNED <u>5/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-15-55</u>	
24. REG. BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE <u>Cornelia D. Morris</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Bertha Larmore</u>		ADDRESS <u>White Haven</u>	

CERTIFICATE OF DEATH

1955

Form 100-100

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

BUREAU V. S.

MAY 16 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5087

CERTIFICATE OF DEATH

05101

332

Reg. Dist. No.

Item 9, Film G182 6-1-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>12 SALISBURY</u>		<u>23 DAYS</u>		TOWN <u>12 SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82 PENINSULA GENERAL HOSP.</u>				<u>306 BOWLIN LANE 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FAIRY</u> (Middle) <u>LEATHERBURY</u> (Last)				(Month) <u>MAY</u> (Day) <u>23</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>COLOR</u>		<u>4-22-1870</u>	<u>85</u> yrs.	Months <u>1</u>	Days <u>1</u>	Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Domestic</u>			<u>Cook</u>		<u>Quantico Wicomico Co. Md.</u>		<u>U.S.A</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Miss Martha Hudson 306 Bowlin Lane Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				<u>Cerebral Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Hypertension</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>20 days</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 3, 1955</u> , to <u>May 23, 1955</u> , that I last saw the deceased alive on <u>May 22, 1955</u> , and that death occurred at <u>4:14 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>E. Herbert Semble</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>5/23/55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>10-4-1-1</u>		<u>5-25-55</u>		<u>Green Acres Memorial Park</u>		<u>Salisbury, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 26, 1955</u>		<u>Mary H. Holloway</u>		<u>Mary A. Stewart</u>		<u>324 E. Church St. Salisbury, Md.</u>	

CERTIFICATE OF DEATH

Part

Form No. 10

1. DEATH CERTIFICATE OF DEATH

2. DEATH CERTIFICATE OF DEATH

3. DEATH CERTIFICATE OF DEATH

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45. DEATH CERTIFICATE OF DEATH

BUREAU V. S.

MAY 26 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5122

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05192
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Fruitland</u>		LENGTH OF STAY (in this place) <u>8 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Fruitland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mills St.</u>				STREET ADDRESS (If rural, give location) <u>Mills St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Mary Elizabeth Leatherbury</u>				4. DATE OF DEATH <u>5</u> <u>13</u> <u>19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>O</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1911</u>	9. AGE last birthday: <u>44</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Kitchen helper</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Hospital</u>		11. BIRTHPLACE (State or foreign country): <u>Mardela, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James E. Hull</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>219-01-7525</u>		17. INFORMANT & ADDRESS: <u>George Leatherbury, Fruitland, Maryland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY No.: <u>219-01-7525</u>			
17. INFORMANT & ADDRESS: <u>George Leatherbury, Fruitland, Maryland</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Crown Occlusion</u>							
DUE TO							
Antecedent cause(s) (b) <u>Plumal Effusion</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:		19c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Ed L. Rye</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-16-55</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mardela Cemetary</u>		LOCATION (City, town, or county) (State) <u>Mardela, Md.</u>	
DATE REC'D BY LOCAL REG <u>17-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Mary A. Stewart</u>		ADDRESS <u>324 E. Church St. Salisbury, Maryland</u>	

RECEIVED

MAY 10 1945

BUREAU V. S.

George Washington, University, Maryland

No

No

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5088

CERTIFICATE OF DEATH

05193

33✓

Dr. Harry Mattox

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
12 Salisbury				12 East William St. Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 Pen. Gen. Hospital				East William St			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) IDA		(Middle) GERTRUDE		(Last) LEWIS		(Month) (Day) (Year)	
MAY		26		th		19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	May 14, 1877	78	Months 0	Days 12	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Work		At Home		R.D. # Berlin Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lemuel Clark				Leah Snack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Mrs. Alton Brittingham 403 Mount St. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
587.0 IMMEDIATE CAUSE (A) Cardiac failure				INTERVAL BETWEEN ONSET AND DEATH 30 days			
ANTECEDENT CAUSE(S) DUE TO (B) Bronchopneumonia				5 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) General debility				2 wks			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Acute pancreatitis				2 wks			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
2							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 11, 1955 , to May 26, 1955 , that I last saw the deceased alive on May 25, 1955 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
SIGNATURE Harry Mattox				DATE SIGNED May 28, 1955			
M.D. Camden Ave. Salisbury, Maryland				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		May 28, 1955		Parsons Cemetery		Salisbury, Maryland	
24. RECD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE May 31, 1955		Mary T. Holloway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

CERTIFICATE OF DEATH

Name of Deceased <i>John Doe</i>		Sex <i>Male</i>		Age <i>45</i>		Date of Death <i>May 15, 1955</i>		Place of Death <i>Home</i>		Cause of Death <i>Heart failure</i>	
Manner of Death <i>Natural</i>		Occupation <i>Teacher</i>		Usual Residence <i>123 Main St, City</i>		Date of Birth <i>May 15, 1910</i>		Place of Birth <i>City, State</i>		Signature of Physician <i>Dr. J. K. Smith</i>	
Signature of Informant <i>John Doe</i>		Relationship to Deceased <i>Spouse</i>		Signature of Informant <i>John Doe</i>		Relationship to Deceased <i>Spouse</i>		Signature of Informant <i>John Doe</i>		Relationship to Deceased <i>Spouse</i>	

*Heart failure
Coronary artery
disease
with
hypertension*

*John Doe
Teacher
123 Main St
City, State*

BUREAU V. S.

MAY 31 1955

RECEIVED

*John Doe
Teacher
123 Main St
City, State*

May 28, 1955 Bureau Director

RECEIVED

1. INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5089

05104

CERTIFICATE OF DEATH

Dr. Carrie Hearn

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mardela Springs</u>		X	
TOWN <u>82</u>				STREET ADDRESS <u>R.D. # 1 (Athol)</u>		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL</u>							
3. NAME OF DECEASED (Type or Print) <u>John Thomas MAJORS</u>				4. DATE OF DEATH <u>May 12 19 55</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>MARCH 21-1873</u>	
9. AGE last birthday <u>82</u> yrs.		10. DATE OF BIRTH		11. BIRTHPLACE (State or foreign country) <u>Mardela Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired FARMER ON FARM</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>James Majors</u>				14. MOTHER'S MAIDEN NAME <u>Priscella EVANS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>UNK</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MRS. ANNIE MAJORS (Wife)</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Heart Block</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/11/55</u> , 19 <u>55</u> , to <u>5/12/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/12/55</u> , 19 <u>55</u> , and that death occurred at <u>7:50 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Carrie J. Hearn</u>		M.D.		ADDRESS (Street, city, town, state) <u>1136 Church St. City</u>		DATE SIGNED <u>5/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Athol Baptist Cem.</u>		LOCATION (City, town, or county) (State) <u>R.D. MARDELA (Athol) Md.</u>	
24. DEC'D BY REGISTRAR <u>May 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Company</u>		ADDRESS <u>Salisbury Md.</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

AT WHAT RESIDENCE DECEASED

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BUREAU V. S.

MAY 16 1955

RECEIVED

Hollway Company - Baltimore, Md.

5/15/55

Dr. George J. H. H. H.

5/15/55

5/15/55

5/15/55

CERTIFICATE OF DEATH

Reg. Dist. No. 332

5090
Item 9, Film 184 8-3-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stockton</u>	<u>23X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Clemmon</u>	(Middle)	(Last) <u>Martin</u>	OF DEATH: <u>May 28 1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>May 16, 1891</u>
9. AGE last birthday <u>64 1/2</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>George Martin</u>		14. MOTHER'S MAIDEN NAME: <u>Nellie Manuel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>3 no</u>		16. SOCIAL SECURITY NO. <u>219-07-3785</u>	
17. INFORMANT & ADDRESS: <u>Annie Martin, Stockton Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis & Hemiplegia</u>		<u>3 day</u>	
ANTECEDENT CAUSE (S) (B) <u>Hypertensive C-V Disease</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>5/27</u> , 19 <u>55</u> , to <u>5/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/27</u> , 19 <u>55</u> , and that death occurred at <u>6:20</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>Amelia Gray</u>		DATE SIGNED <u>5/28/55</u>	
M. D. <u>Salisbury Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>65-31-531</u>		NAME OF CEMETERY OR CREMATORY <u>Stockton Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Stockton Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>9-31-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	
24. FUNERAL DIRECTOR <u>Edgar & Sons</u>		ADDRESS <u>100 North New Church</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

JUN 3 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5091

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05106
Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u> <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>24 hrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Chance</u> <u>19X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James</u> <u>McBride</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>25</u> <u>19 55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Oct 15 1884</u>	9. AGE last birthday: <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Widow - James</u>				10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Chance</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jermuel McBride</u>				14. MOTHER'S MAIDEN NAME: <u>Leah Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>220-03-602</u>		17. INFORMANT & ADDRESS: <u>J. Elwood McBride</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
153X Immediate cause (a) <u>Intestinal obstruction</u> DUE TO						3 days	
Antecedent cause(s) (b) <u>Carcinoma of the colon</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						unknown	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>						19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl R. Royce</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>5-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Chance Cem</u>		LOCATION (City, town, or county) (State) <u>Chance Md.</u>	
DATE REC'D BY LOCAL REG <u>5-27-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Booker M. Welsh - Salisbury Md.</u>		ADDRESS	

BUREAU V. S.

MAY 31 1955

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

I TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5092

CERTIFICATE OF DEATH

05108

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>SALISBURY</u>		28 Days		TOWN <u>SALISBURY</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>PENINSULA GENERAL HOSPITAL</u>				112 LAKE STREET 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
<u>THOMAS Elwood McGEE</u>				<u>MAY 30 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>WHITE</u>	<u>SEPARATED</u>	<u>FEB 10, 1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>UNKNOWN</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>UNKNOWN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Y</u>		<u>239-30-7392</u>		<u>Wicomico County Welfare Board</u> <u>SALISBURY, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
540.1 IMMEDIATE CAUSE (A)				<u>Intestinal obstructions & bilary fistula</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO				<u>Chronic peptic ulcer</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>4 wks.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>5-8-55</u>		<u>Bleeding peptic ulcer & perforation into pancreas</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY (street, office bldg., etc.))		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/2</u> , 19 <u>55</u> , to <u>5/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>55</u> , and that death occurred at <u>3:10</u> P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>William H. Fisher M.D.</u>				<u>SALISBURY, Md.</u>			
DATE				DATE SIGNED			
<u>June 3, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2 June 1955</u>		<u>PARSONS CEMETERY</u>		<u>SALISBURY, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Mary H. Holloway</u>		<u>Thomas T. Wallace</u>		<u>Salisbury, Md.</u>	

CERTIFICATE OF DEATH

Rev. Edw. H. H.

ST. LOUIS NEW ORLEANS MEMPHIS OF DEATH

PLACE OF BIRTH

NAME

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

Feb 10, 1886

Unknown

Unknown

Unknown

231-30-1392

Wisconsin County Institute Fund
Baltimore, Md.

BUREAU V. 2

JUN 3 1955

RECEIVED
Baltimore, Md.

James F. Williams
General
James F. Williams
General

5123

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05109
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Wicomico		STATE Md.		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Pittsville		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		Pittsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		R.D. #		STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		(First) OWEN		(Middle) OLIVER		(Last) MC NEAL	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		White		Divorced		March 6, 1900	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		Justice of Peace		9. AGE last birthday:		55 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY:		Talbot County Maryland		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:		Daniel R. Mc Neal		14. MOTHER'S MAIDEN NAME:		Lena Webb	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:		Mr. Gragan McNeal (Brother) Wilmington, Del.	
Unk							
18. MEDICAL CERTIFICATION				1226 King St.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
976X Immediate cause (a).....				Bullet wound of Brain			
Antecedent cause(s) (h).....							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office hldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <input checked="" type="checkbox"/> May 2 1955			
23. BURIAL, CREMATION, REMOVAL (Specify):				NAME OF CEMETERY OR CREMATORY			
Cremation				J. Wm Lee - Son F. H. Washington D.C.			
DATE REC'D BY LOCAL REG.				24. FUNERAL DIRECTOR ADDRESS			
3-2-53				MOLLOWAY & COMPANY SALISBURY MARYLAND			

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 5 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05110

5124

CERTIFICATE OF DEATH

Dr. ~~MESSICK~~ Harich

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Tyaskin</u>				TOWN <u>Tyaskin</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>at Home</u>				<u>at Home</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u> (Middle) <u>MARGARET</u> (Last) <u>MESSICK</u>				(Month) <u>May</u> (Day) <u>12</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>May 23, 1874</u>	<u>80</u> yrs.	Months <u>11</u> Days <u>19</u>	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Work & Worked in Local Store</u>				<u>Tyaskin, Maryland Wico. Co.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John A. Weinwright</u>				<u>Alice Elizabeth Efford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Mr. Harry L. Messick (Son) Tyaskin, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>1 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12, 19 55</u> to <u>May 12, 19 55</u> that I last saw the deceased alive on <u>May 12, 19 55</u> , and that death occurred at <u>7:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William E. Messick</u>				DATE SIGNED <u>May 13, 1955</u>			
M.D. <u>Hebron, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>May 15, 1955</u>		<u>Wicomico Memorial Park</u>		<u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 16, 1955</u>		<u>Mary H. Holloway</u>		<u>HOLLOWAY & COMPANY</u>		<u>SALISBURY MARYLAND</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Print or Type)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CLERK

21. SIGNATURE OF ASSISTANT CLERK

22. SIGNATURE OF RECEPTIONIST

23. SIGNATURE OF TELEPHONE OPERATOR

24. SIGNATURE OF MAIL ROOM

25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF STATISTICS SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF RADIOLOGY

29. SIGNATURE OF PATHOLOGY

30. SIGNATURE OF BACTERIOLOGY

31. SIGNATURE OF VIROLOGY

32. SIGNATURE OF IMMUNOLOGY

33. SIGNATURE OF EPIDEMIOLOGY

34. SIGNATURE OF PUBLIC HEALTH

35. SIGNATURE OF NURSING

36. SIGNATURE OF DENTISTRY

37. SIGNATURE OF OPTOMETRY

38. SIGNATURE OF PODIATRY

39. SIGNATURE OF PHYSICIAN ASSISTANT

40. SIGNATURE OF NURSE ASSISTANT

41. SIGNATURE OF LABORATORY ASSISTANT

42. SIGNATURE OF RADIOLOGY ASSISTANT

43. SIGNATURE OF PATHOLOGY ASSISTANT

44. SIGNATURE OF BACTERIOLOGY ASSISTANT

45. SIGNATURE OF VIROLOGY ASSISTANT

46. SIGNATURE OF IMMUNOLOGY ASSISTANT

47. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

48. SIGNATURE OF PUBLIC HEALTH ASSISTANT

49. SIGNATURE OF NURSING ASSISTANT

50. SIGNATURE OF DENTISTRY ASSISTANT

51. SIGNATURE OF OPTOMETRY ASSISTANT

52. SIGNATURE OF PODIATRY ASSISTANT

53. SIGNATURE OF PHYSICIAN ASSISTANT

54. SIGNATURE OF NURSE ASSISTANT

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59. SIGNATURE OF VIROLOGY ASSISTANT

60. SIGNATURE OF IMMUNOLOGY ASSISTANT

61. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

62. SIGNATURE OF PUBLIC HEALTH ASSISTANT

63. SIGNATURE OF NURSING ASSISTANT

64. SIGNATURE OF DENTISTRY ASSISTANT

65. SIGNATURE OF OPTOMETRY ASSISTANT

66. SIGNATURE OF PODIATRY ASSISTANT

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71. SIGNATURE OF PATHOLOGY ASSISTANT

72. SIGNATURE OF BACTERIOLOGY ASSISTANT

73. SIGNATURE OF VIROLOGY ASSISTANT

74. SIGNATURE OF IMMUNOLOGY ASSISTANT

75. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

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80. SIGNATURE OF PODIATRY ASSISTANT

81. SIGNATURE OF PHYSICIAN ASSISTANT

82. SIGNATURE OF NURSE ASSISTANT

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102. SIGNATURE OF IMMUNOLOGY ASSISTANT

103. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

104. SIGNATURE OF PUBLIC HEALTH ASSISTANT

105. SIGNATURE OF NURSING ASSISTANT

106. SIGNATURE OF DENTISTRY ASSISTANT

107. SIGNATURE OF OPTOMETRY ASSISTANT

108. SIGNATURE OF PODIATRY ASSISTANT

109. SIGNATURE OF PHYSICIAN ASSISTANT

110. SIGNATURE OF NURSE ASSISTANT

111. SIGNATURE OF LABORATORY ASSISTANT

112. SIGNATURE OF RADIOLOGY ASSISTANT

113. SIGNATURE OF PATHOLOGY ASSISTANT

114. SIGNATURE OF BACTERIOLOGY ASSISTANT

115. SIGNATURE OF VIROLOGY ASSISTANT

116. SIGNATURE OF IMMUNOLOGY ASSISTANT

117. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

118. SIGNATURE OF PUBLIC HEALTH ASSISTANT

119. SIGNATURE OF NURSING ASSISTANT

120. SIGNATURE OF DENTISTRY ASSISTANT

121. SIGNATURE OF OPTOMETRY ASSISTANT

122. SIGNATURE OF PODIATRY ASSISTANT

123. SIGNATURE OF PHYSICIAN ASSISTANT

124. SIGNATURE OF NURSE ASSISTANT

125. SIGNATURE OF LABORATORY ASSISTANT

126. SIGNATURE OF RADIOLOGY ASSISTANT

127. SIGNATURE OF PATHOLOGY ASSISTANT

128. SIGNATURE OF BACTERIOLOGY ASSISTANT

129. SIGNATURE OF VIROLOGY ASSISTANT

130. SIGNATURE OF IMMUNOLOGY ASSISTANT

131. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

132. SIGNATURE OF PUBLIC HEALTH ASSISTANT

133. SIGNATURE OF NURSING ASSISTANT

134. SIGNATURE OF DENTISTRY ASSISTANT

135. SIGNATURE OF OPTOMETRY ASSISTANT

136. SIGNATURE OF PODIATRY ASSISTANT

137. SIGNATURE OF PHYSICIAN ASSISTANT

138. SIGNATURE OF NURSE ASSISTANT

139. SIGNATURE OF LABORATORY ASSISTANT

140. SIGNATURE OF RADIOLOGY ASSISTANT

141. SIGNATURE OF PATHOLOGY ASSISTANT

142. SIGNATURE OF BACTERIOLOGY ASSISTANT

143. SIGNATURE OF VIROLOGY ASSISTANT

144. SIGNATURE OF IMMUNOLOGY ASSISTANT

145. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

146. SIGNATURE OF PUBLIC HEALTH ASSISTANT

147. SIGNATURE OF NURSING ASSISTANT

148. SIGNATURE OF DENTISTRY ASSISTANT

149. SIGNATURE OF OPTOMETRY ASSISTANT

150. SIGNATURE OF PODIATRY ASSISTANT

151. SIGNATURE OF PHYSICIAN ASSISTANT

152. SIGNATURE OF NURSE ASSISTANT

153. SIGNATURE OF LABORATORY ASSISTANT

154. SIGNATURE OF RADIOLOGY ASSISTANT

155. SIGNATURE OF PATHOLOGY ASSISTANT

156. SIGNATURE OF BACTERIOLOGY ASSISTANT

157. SIGNATURE OF VIROLOGY ASSISTANT

158. SIGNATURE OF IMMUNOLOGY ASSISTANT

159. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

160. SIGNATURE OF PUBLIC HEALTH ASSISTANT

161. SIGNATURE OF NURSING ASSISTANT

162. SIGNATURE OF DENTISTRY ASSISTANT

163. SIGNATURE OF OPTOMETRY ASSISTANT

164. SIGNATURE OF PODIATRY ASSISTANT

165. SIGNATURE OF PHYSICIAN ASSISTANT

166. SIGNATURE OF NURSE ASSISTANT

167. SIGNATURE OF LABORATORY ASSISTANT

168. SIGNATURE OF RADIOLOGY ASSISTANT

169. SIGNATURE OF PATHOLOGY ASSISTANT

170. SIGNATURE OF BACTERIOLOGY ASSISTANT

171. SIGNATURE OF VIROLOGY ASSISTANT

172. SIGNATURE OF IMMUNOLOGY ASSISTANT

173. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

174. SIGNATURE OF PUBLIC HEALTH ASSISTANT

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178. SIGNATURE OF PODIATRY ASSISTANT

179. SIGNATURE OF PHYSICIAN ASSISTANT

180. SIGNATURE OF NURSE ASSISTANT

181. SIGNATURE OF LABORATORY ASSISTANT

182. SIGNATURE OF RADIOLOGY ASSISTANT

183. SIGNATURE OF PATHOLOGY ASSISTANT

184. SIGNATURE OF BACTERIOLOGY ASSISTANT

185. SIGNATURE OF VIROLOGY ASSISTANT

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187. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

188. SIGNATURE OF PUBLIC HEALTH ASSISTANT

189. SIGNATURE OF NURSING ASSISTANT

190. SIGNATURE OF DENTISTRY ASSISTANT

191. SIGNATURE OF OPTOMETRY ASSISTANT

192. SIGNATURE OF PODIATRY ASSISTANT

193. SIGNATURE OF PHYSICIAN ASSISTANT

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195. SIGNATURE OF LABORATORY ASSISTANT

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219. SIGNATURE OF OPTOMETRY ASSISTANT

220. SIGNATURE OF PODIATRY ASSISTANT

221. SIGNATURE OF PHYSICIAN ASSISTANT

222. SIGNATURE OF NURSE ASSISTANT

223. SIGNATURE OF LABORATORY ASSISTANT

224. SIGNATURE OF RADIOLOGY ASSISTANT

225. SIGNATURE OF PATHOLOGY ASSISTANT

226. SIGNATURE OF BACTERIOLOGY ASSISTANT

227. SIGNATURE OF VIROLOGY ASSISTANT

228. SIGNATURE OF IMMUNOLOGY ASSISTANT

229. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

230. SIGNATURE OF PUBLIC HEALTH ASSISTANT

231. SIGNATURE OF NURSING ASSISTANT

232. SIGNATURE OF DENTISTRY ASSISTANT

233. SIGNATURE OF OPTOMETRY ASSISTANT

234. SIGNATURE OF PODIATRY ASSISTANT

235. SIGNATURE OF PHYSICIAN ASSISTANT

236. SIGNATURE OF NURSE ASSISTANT

237. SIGNATURE OF LABORATORY ASSISTANT

238. SIGNATURE OF RADIOLOGY ASSISTANT

239. SIGNATURE OF PATHOLOGY ASSISTANT

240. SIGNATURE OF BACTERIOLOGY ASSISTANT

241. SIGNATURE OF VIROLOGY ASSISTANT

242. SIGNATURE OF IMMUNOLOGY ASSISTANT

243. SIGNATURE OF EPIDEMIOLOGY ASSISTANT

244. SIGNATURE OF PUBLIC HEALTH ASSISTANT

245. SIGNATURE OF NURSING ASSISTANT

246. SIGNATURE OF DENTISTRY ASSISTANT

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05111

5125

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Mardela Springs, Md.</u>				TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Shades Nursing Home</u>				STREET ADDRESS (If rural give location) <u>511 Jackson Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lillian Mitchell</u>				<u>May 27 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Oct. 1892</u>	<u>62</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>at home</u>		<u>at home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Martha Esham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>no</u>		<u>511 Jackson St. Milton L. Mitchell Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
581.0 IMMEDIATE CAUSE (A) <u>Cerebral Palsy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cerebral Palsy</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 17, 1954</u>, to <u>May 26, 1955</u>, that I last saw the deceased alive on <u>May 26, 1955</u>, and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Has. Kuhlman</u> M. D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>5/28/55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>29 May 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) <u>Salisbury Maryland</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert T. Challen</u>		ADDRESS <u>Salisbury, Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5093

05112

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>RT. # 5</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MURTLE</u> (Middle) <u>ETHEL</u> (Last) <u>PARSONS</u>				(Month) <u>MAY</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 4, 1909</u>	
				9. AGE last birthday <u>45</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Operator at Shirt Factory</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury Maryland</u>	
13. FATHER'S NAME <u>Charles B. Pruitt</u>				14. MOTHER'S MAIDEN NAME <u>Sarah F. Tyndall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. N. Wilton Parsons (Husband) R.D. #55 Salisbury, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
196X IMMEDIATE CAUSE (A) <u>Hemorrhagic Stroke</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Sarcoma Mandible</u>						<u>2 1/2 Yrs App.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Sarcoma Soft Tissues Neck</u>						<u>1 Yr App.</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 2, 1955</u> , to <u>MAY 19, 1955</u> , that I last saw the deceased alive on <u>MAY 2, 1955</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John M. Blopham III</u> M.D. <u>Salisbury, Maryland</u>				DATE SIGNED <u>5-19-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			
DATE <u>5-20-55</u>							

CERTIFICATE OF DEATH

4003

Reg. No. 11

1. NAME OF DECEASED: HENRY, JAMES

2. SEX: MALE

3. PLACE OF BIRTH: BALTIMORE, MD.

4. AGE: 65

5. OCCUPATION: RETIRED

6. DATE OF DEATH: MAY 20, 1955

7. TIME OF DEATH: 10:30 AM

8. PLACE OF DEATH: HOME

9. CAUSE OF DEATH: HEART DISEASE

10. MANNER OF DEATH: NATURAL

11. SIGNATURE OF PHYSICIAN: J. H. SMITH

12. SIGNATURE OF REGISTRAR: J. H. SMITH

13. MEDICAL CERTIFICATE: YES

14. THIS CERTIFICATE IS VALID FOR: 10 YEARS

15. DATE OF EXPIRATION: MAY 20, 1965

16. SIGNATURE OF PHYSICIAN: J. H. SMITH

17. SIGNATURE OF REGISTRAR: J. H. SMITH

18. SIGNATURE OF PHYSICIAN: J. H. SMITH

19. SIGNATURE OF REGISTRAR: J. H. SMITH

20. SIGNATURE OF PHYSICIAN: J. H. SMITH

21. SIGNATURE OF REGISTRAR: J. H. SMITH

22. SIGNATURE OF PHYSICIAN: J. H. SMITH

23. SIGNATURE OF REGISTRAR: J. H. SMITH

24. SIGNATURE OF PHYSICIAN: J. H. SMITH

25. SIGNATURE OF REGISTRAR: J. H. SMITH

26. SIGNATURE OF PHYSICIAN: J. H. SMITH

27. SIGNATURE OF REGISTRAR: J. H. SMITH

28. SIGNATURE OF PHYSICIAN: J. H. SMITH

29. SIGNATURE OF REGISTRAR: J. H. SMITH

BUREAU V. S.

MAY 20 1955

RECEIVED

EXHIBIT

THIS CERTIFICATE IS VALID FOR 10 YEARS FROM THE DATE OF DEATH. IT IS NOT VALID FOR ANY OTHER PURPOSE. IT IS NOT VALID FOR ANY OTHER PURPOSE. IT IS NOT VALID FOR ANY OTHER PURPOSE.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5126

05113

CERTIFICATE OF DEATH

Dr. Beardsley

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN Rural Parsonsburg		LENGTH OF STAY (in this place)		CITY OR TOWN Rural Parsonsburg		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 2				STREET ADDRESS R.D. # 2			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) OLEVIA		(Middle) ERNIE		(Last) PARSONS		(Month) MAY (Day) 30 (Year) 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 17, 1872	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months 7 Days 13		Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Wicomico County R.D. # 2 Parsonsburg Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J.B. Perdue				14. MOTHER'S MAIDEN NAME Mary Nester Innis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Estelle L. Dennis (Daughter) R.D. # 2 Parsonsburg, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) cerebral hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
ANTECEDENT CAUSE(S) DUE TO (B) essential hypertension				10 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 19 55 , to May 20, 19 55 , that I last saw the deceased alive on May 29, 19 55 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.							
SIGNATURE Carl W. Beardsley				DATE SIGNED May 31, 1955			
M.D. East Church St Salisbury, Maryland				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 2, 1955		NAME OF CEMETERY OR CREMATORY Bethel Cemetery		LOCATION (City, town, or county) (State) Walston Md. Near Salisbury Md	
24. REC'D BY REGISTRAR B. J. Dayton		REGISTRAR'S SIGNATURE Mary Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
DATE June 2, 1955							

CERTIFICATE OF DEATH

Dr. Kennedy

Place of Death

Wicomico

Maryland

John J. Kennedy

John J. Kennedy

Age

Age

Sex

Sex

Sex

Sex

Married

Married

Married

Married

John J. Kennedy

John J. Kennedy

John J. Kennedy

John J. Kennedy

BUREAU V. 31

JUN 2 1955

RECEIVED

John J. Kennedy

John J. Kennedy

John J. Kennedy

John J. Kennedy

5094

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY

Wicomico

MARYLAND

CITY (If outside corporate limits, write RURAL or and give nearest town)

12 TOWN

Salisbury

LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Worcester

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Berlin Maryland 23X-2

STREET ADDRESS

(If rural give location)

RR # 2

82 HOSPITAL OR INSTITUTION OR STREET ADDRESS

Peninsula General Hospital

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Powell

4. DATE (Month) (Day) (Year)

OF DEATH:

May 12 1955

5. SEX:

Female

6. COLOR OR RACE:

Wh. Te

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

May 12, 1955

9. AGE last birthday

IF UNDER 1 YEAR Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

Mason

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Ollie Ray Powell

14. MOTHER'S MAIDEN NAME:

Pauline Emily West

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

761.0 IMMEDIATE CAUSE

(A)

Annoa due to

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Premature Separation of

DUE TO

(C)

Placenta

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased

alive on , 19....., and that death occurred at M, from the causes and on the date stated above.

SIGNATURE

Robert Lee Book

M. D.

ADDRESS

DATE SIGNED

5-15-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-15-55

Mary W. Holloway

Peninsula General Hospital

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 - 10 - 53

2055274360

RECEIVED

MAY 18 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS 4-15-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05115

CERTIFICATE OF DEATH

Dr. Harry Mattox

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 409 East Vine St</u>				STREET ADDRESS (If rural give location) <u>409 East Vine St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u>		(Middle) <u>M ANLAF</u>		(Last) <u>FUSEY</u>		(Month) <u>MAY</u> (Day) <u>21</u> (Year) <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 3, 1884</u>		9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Night Watchman Lumber Yard</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Sussex Co. Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John S. Fusey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Workman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Mona F. Fusey (Wife) 409 E. Vine St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.1 Acute myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>coronary artery occlusion</u> <u>15 min</u>			
(C) <u>generalized arteriosclerosis</u>				<u>10 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>55</u> , and that death occurred at <u>8:20P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Harry Mattox</u>				DATE SIGNED <u>May 23, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>5-25-55</u>		REGISTRAR'S SIGNATURE <u>Mary Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

CERTIFICATE OF DEATH

TO BE FILLED BY THE REGISTRAR

PLACE ON DEATH

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE

DATE OF DEATH

CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH

DATE OF INTERMENT
PLACE OF INTERMENT

DATE OF BURIAL

NAME OF BURIAL PLACE

NAME OF REGISTRAR

DATE OF REGISTRATION

NAME OF REGISTRAR

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DATE OF REGISTRATION

NAME OF REGISTRAR

BUREAU V. 3

MAY 25 1935

RECEIVED

INSTRUCTIONS
1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5096

05116

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MIDDLESEX		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		3 months		TOWN <u>Pocomoke</u>		23-42-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>703 Fourth Street</u> ✓			
3. NAME OF DECEASED (First) (Middle) (Last) <u>SONORA</u> <u>BYRD</u> <u>PUSEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>17</u> <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov. 25, 1866</u>	
9. AGE last birthday <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) <u>Worcester County - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levin Pusey</u>				14. MOTHER'S MAIDEN NAME <u>Susan D. Pope</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>446X</u> IMMEDIATE CAUSE (A) <u>Nephrosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - general</u>				<u>Unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Multiple decubital ulcers</u>				<u>7 months</u>			
19a. DATE OF OPERATION --		19b. MAJOR FINDINGS OF OPERATION --		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) --		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) --			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) --		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? --			
22. I hereby certify that I attended the deceased from <u>Feb. 23, 1955</u> to <u>May 17, 1955</u> that I last saw the deceased <u>alive on</u> <u>May 17, 1955</u> and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		DATE THEREOF <u>May 17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery Pocomoke Md.</u>		LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>5-19-55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary W. Holloway</u>		DATE SIGNED <u>5/17/55</u>	

CERTIFICATE OF DEATH

Form 100-1-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF FUNERAL HOME

12. SIGNATURE OF BURIAL PLACE

13. SIGNATURE OF CORoner

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF PRISONER

22. SIGNATURE OF WARDEN

23. SIGNATURE OF CHIEF OF POLICE

24. SIGNATURE OF DEPUTY CHIEF OF POLICE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF DEPUTY SHERIFF

27. SIGNATURE OF CONSTABLE

28. SIGNATURE OF JAILER

29. SIGNATURE OF PRISONER

30. SIGNATURE OF WARDEN

31. SIGNATURE OF CHIEF OF POLICE

32. SIGNATURE OF DEPUTY CHIEF OF POLICE

33. SIGNATURE OF SHERIFF

34. SIGNATURE OF DEPUTY SHERIFF

35. SIGNATURE OF CONSTABLE

36. SIGNATURE OF JAILER

BUREAU V. 2

MAY 23 1955

RECEIVED

2-19-55. Maryland Department of Health

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5097

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Somerset</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		LENGTH OF STAY (in this place) <i>2 weeks</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Princess Anne</i> 19X-2			
TOWN <i>Salisbury</i>				STREET ADDRESS (If rural give location) <i>R. 7 D.</i> ✓			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Princess Anne General Hospital</i>							
3. NAME OF DECEASED: (First) <i>William</i> (Middle) <i>B</i> (Last) <i>Renshaw</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>May 28 1955</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH: <i>June 20 1860</i>	9. AGE last birthday <i>94</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired Merchant</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Merchant</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>George Renshaw</i>				14. MOTHER'S MAIDEN NAME: <i>Anastasia Nollman</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT & ADDRESS: <i>Mrs. Elise Robert Salisbury</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Bronchopneumonia</i>							
ANTECEDENT CAUSE (S) DUE TO (B) <i>Emphysema & Atherosclerosis</i>						<i>2 wks.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at <i>11:45</i> AM, from the causes and on the date stated above.							
SIGNATURE <i>Willie H. Fitch</i>		M. D. <i>Salisbury, Md.</i>		DATE SIGNED <i>5-29-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>May 30 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Grace Cemetery</i>		LOCATION (City, town, or county) (State) <i>Mt. Vernon, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6-2-55</i>		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		24. FUNERAL DIRECTOR <i>Leona B. Nelson</i>		ADDRESS <i>Princess Anne</i>	

BUREAU V. S.

JUN 6 1955

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

5098

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05118

332

Items 8,9: film G181 5-24-55 L

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>4 years</u>		CITY OR TOWN <u>Baltimore</u>		3701-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>		STREET ADDRESS <u>2013 McCulloh Street</u>		(If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOSIE VIRGINIA SMITH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 16 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>2/17/1893</u> 1903	9. AGE last birthday <u>62</u> 52 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u>		11. BIRTHPLACE (State or foreign country) <u>Cooksville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Smith</u>				14. MOTHER'S MAIDEN NAME <u>Liza Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>023X</u> IMMEDIATE CAUSE (A) <u>Luetic heart disease</u>						?	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Lues</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CNS syphilis</u>						? 4 years	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>May 22</u> , 19 <u>51</u> , to <u>May 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>55</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. V. Juerman</u>		V. Juerman, M.D. M.D. <u>Salisbury, Maryland</u>		ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital</u>		DATE SIGNED <u>5/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>		LOCATION (City, town, or county) (State) <u>Cooksville, Md.</u>	
24. RECEIVED BY REGISTRAR <u>May 24, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Willard H. Hight</u>		ADDRESS <u>Cooksville, Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Somerset.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marion.</u> TOWN <u>Marion.</u> STREET ADDRESS (If rural give location) <u>19X-2</u>			
3. NAME OF DECEASED (Type or Print) <u>Jennie</u> (First) <u>May</u> (Middle) <u>Swift.</u> (Last)				4. DATE OF DEATH <u>May</u> (Month) <u>3</u> (Day) <u>1955</u> (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow.</u>	8. DATE OF BIRTH <u>8/31/1870</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Marion, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus ENNIS.</u>				14. MOTHER'S MAIDEN NAME <u>NELLIE MATTHEWS.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>HOSPITAL RECORDS.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE,</u>				<u>unknown</u>			
ANTECEDENT CAUSE(S) <u>DEEP</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Arteriosclerotic Brain syndrome</u>				<u>II</u>			
(C) <u>ARTERIOSCLEROSIS GENERAL.</u>				<u>II</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DEEP MULTIPLE DECUBITI.</u>				<u>3 mo.</u>			
19a. DATE OF OPERATION <u>5/3</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>II/4</u> , 19 <u>54</u> , to <u>5/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/3</u> , 19 <u>55</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. J. Juerman</u>		M.D.		ADDRESS (Street, city, town, state) <u>Deer's Head Hospital-Salisbury, Md.</u>		DATE SIGNED <u>5/3/55</u>	
23. BURIAL, CREMATION, REMOVAL <u>Burial</u>		DATE THEREOF <u>May 5, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Sunnyridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield Maryland</u>	
24. REC'D BY REGISTRAR <u>May 6, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons-531 Main St.-Crisfield, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. DATE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF BIRTH

11. DATE OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

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MAY 6 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

5100

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05120

Dr. Wm. B. Smith

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>302 Oak St</u>				STREET ADDRESS (If rural give location) <u>302 Oak St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u> (Middle) <u>(Franklin)</u> (Last) <u>THORNTON</u>				(Month) <u>MAY</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 11, 1871</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months <u>9</u>	Days <u>27</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Thornton</u>				14. MOTHER'S MAIDEN NAME <u>Janie Killman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS <u>Mrs. Rickard Long 302 Oak St. Salisbury</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch. Hypertensive CV. Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardiac insufficiency</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1955</u> to <u>May 8, 1955</u> , that I last saw the deceased alive on <u>May 8, 1955</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. B. Smith</u>				DATE SIGNED <u>May 11 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>May 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		LOCATION (City, town, or county) <u>Salisbury, Maryland</u>		(State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
DATE <u>May 13, 1955</u>							

CERTIFICATE OF DEATH

FILE NO.

DEATH NUMBER (MAY 1955)

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5101

Dr. Wm Smith

CERTIFICATE OF DEATH

05121

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY <u>Salisbury</u>		CITY <u>Salisbury</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>		CITY OR TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>1021 Cecil St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>SEWELL HENRY TINGLE</u>				<u>May 15 th 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 1, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months <u>0</u> Days <u>14</u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Safty Man</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dupont Co.</u>		11. BIRTHPLACE (State or foreign country) <u>R.D. # Delmar, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Daniel Henry Tingle</u>				14. MOTHER'S MAIDEN NAME <u>Julia Martha Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Virginia Derby (Daughter) 1021 Cecil St. Salisbury, Maryland</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebro-vascular Accident</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive C.V. Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/10/55</u> , to <u>5-15-55</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>55</u> , and that death occurred at <u>8:50A.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Wm B Smith</u> DATE SIGNED <u>May 16 1955</u> ADDRESS (Street, city, town, state) <u>N. Division St. Salisbury, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>May 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

CERTIFICATE OF DEATH

TO BE COMPLETED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE DEATH

TO BE COMPLETED BY THE REGISTRAR

NAME OF DECEASED: JOHN J. SMITH
 SEX: MALE AGE: 45 YEARS
 DATE OF BIRTH: 1910 PLACE OF BIRTH: NEW YORK

RESIDENCE: 1234 MAIN ST. BALTIMORE, MD.
 OCCUPATION: CLERK

CAUSE OF DEATH: HEART DISEASE
 MANNER OF DEATH: NATURAL

DATE OF DEATH: MAY 15 1955
 PLACE OF DEATH: HOME

SIGNATURE OF PHYSICIAN: [Signature]
 SIGNATURE OF REGISTRAR: [Signature]

DATE OF REGISTRATION: MAY 18 1955
 PLACE OF REGISTRATION: BALTIMORE, MD.

NAME OF REGISTRAR: [Name]
 NAME OF PHYSICIAN: [Name]

NAME OF DECEASED: JOHN J. SMITH
 SEX: MALE AGE: 45 YEARS

DATE OF BIRTH: 1910 PLACE OF BIRTH: NEW YORK
 RESIDENCE: 1234 MAIN ST. BALTIMORE, MD.

OCCUPATION: CLERK
 CAUSE OF DEATH: HEART DISEASE

MANNER OF DEATH: NATURAL
 DATE OF DEATH: MAY 15 1955

PLACE OF DEATH: HOME
 SIGNATURE OF PHYSICIAN: [Signature]

BUREAU V. S.

MAY 18 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5102

CERTIFICATE OF DEATH

05122

Dr. Mattax, Alberta

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS <u>531 Priscilla St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ROBERT</u>		(Middle) <u>AUSTIN</u>		(Last) <u>TODD</u>		(Month) <u>MAY</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 29, 1906</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR: Months <u>1</u> Days <u>14</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>		11. BIRTHPLACE (State or foreign country) <u>Crocheron Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Nathan Todd</u>				14. MOTHER'S MAIDEN NAME <u>Sankey Truitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Stella Virginia Todd - 531 Priscilla St. Salisbury, Maryland</u>		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
202.0 IMMEDIATE CAUSE (A) <u>Air embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Thrombocytopenia</u>				<u>5 "</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Giant Follicular lymphoblastoma</u>				<u>1 1/2 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN</u> , 19 <u>54</u> , to <u>MAY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>MAY 13, 1955</u> , and that death occurred at <u>12:05</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>Alberta Mattax</u>				ADDRESS (Street, city, town, state) <u>711 Camden Ave. Salisbury, Md.</u> DATE SIGNED <u>May 13 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>Mary J. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
DATE <u>May 17, 1955</u>							

CERTIFICATE OF DEATH

Reg. No. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF TOWNSHIP CLERK

19. SIGNATURE OF VOTING CLERK

20. SIGNATURE OF TOWN CLERK

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF U.S. CLERK

24. SIGNATURE OF DISTRICT CLERK

25. SIGNATURE OF JUDGE OF PROBATE

26. SIGNATURE OF JUDGE OF SUPERIOR COURT

27. SIGNATURE OF JUDGE OF COMMON PLEAS

28. SIGNATURE OF JUDGE OF CRIMINAL COURT

29. SIGNATURE OF JUDGE OF DISTRICT COURT

30. SIGNATURE OF JUDGE OF PROBATE COURT

31. SIGNATURE OF JUDGE OF SUPERIOR COURT

32. SIGNATURE OF JUDGE OF COMMON PLEAS

33. SIGNATURE OF JUDGE OF CRIMINAL COURT

34. SIGNATURE OF JUDGE OF DISTRICT COURT

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36. SIGNATURE OF JUDGE OF SUPERIOR COURT

37. SIGNATURE OF JUDGE OF COMMON PLEAS

38. SIGNATURE OF JUDGE OF CRIMINAL COURT

39. SIGNATURE OF JUDGE OF DISTRICT COURT

40. SIGNATURE OF JUDGE OF PROBATE COURT

41. SIGNATURE OF JUDGE OF SUPERIOR COURT

42. SIGNATURE OF JUDGE OF COMMON PLEAS

43. SIGNATURE OF JUDGE OF CRIMINAL COURT

44. SIGNATURE OF JUDGE OF DISTRICT COURT

45. SIGNATURE OF JUDGE OF PROBATE COURT

BUREAU V. S.

MAY 17 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5103

CERTIFICATE OF DEATH

05123

Reg. Dist. No. 33✓

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>126 First Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>John Wesley Tull</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 5 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4/21/1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>Allen, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Tull</u>				14. MOTHER'S MAIDEN NAME <u>Julia Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>Coronary insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>Unknown</u>	
(C) <u>Arteriosclerosis - general</u>						<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gangrene of left foot and cerebral thrombosis</u>						<u>1½ months</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>- -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>- -</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>- -</u>			
22. I hereby certify that I attended the deceased from <u>Feb. 9</u> , 19 <u>55</u> , to <u>May 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>55</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>V. Juerman</u>		V. Juerman, M.D.		ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital Salisbury, Maryland</u>		DATE SIGNED <u>5/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>5-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Wells Co. Md.</u>		LOCATION (City, town, or county) (State) <u>Wells Co. Md.</u>	
24. REC'D BY REGISTRAR <u>May 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brother M. West</u>		ADDRESS <u>Salisbury Md.</u>	

CERTIFICATE OF DEATH

Reg. Form No. 10

1. FULL RESIDENCE (HOME OR PLACE OF DEATH)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. NAME OF DECEASED

6. SEX

7. AGE

8. RACE

9. DATE OF BIRTH

10. PLACE OF BIRTH

11. NAME OF DECEASED

12. SEX

13. AGE

14. RACE

15. DATE OF BIRTH

16. PLACE OF BIRTH

17. NAME OF DECEASED

18. SEX

19. AGE

20. RACE

21. DATE OF BIRTH

22. PLACE OF BIRTH

23. NAME OF DECEASED

24. SEX

25. AGE

26. RACE

27. DATE OF BIRTH

28. PLACE OF BIRTH

29. NAME OF DECEASED

30. SEX

31. AGE

32. RACE

33. DATE OF BIRTH

34. PLACE OF BIRTH

35. NAME OF DECEASED

BUREAU V. S.

MAY 13 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05124

5104

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>10 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3 Vol-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>2538 Garrett Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MINNIE ELIZABETH TULL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 31 19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/30/1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House-Work at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Venton, Md. Somerset Co. Habnab, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George McDorman</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Frances Townsend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk. No</u>		16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT & ADDRESS <u>and Mr. Norris W. Tull (Son) Hospital records 1102 N. Division St Salisbury, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Uremia</u>				<u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephrosclerosis</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis - general</u>				<u>?</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive cardiovascular disease</u>				<u>?</u>			
19a. DATE OF OPERATION <u>- - -</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - -</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>- - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>- - -</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>- - -</u>			
22. I hereby certify that I attended the deceased from <u>July 20, 19 54</u> , to <u>May 31, 19 55</u> , that I last saw the deceased alive on <u>May 31, 19 55</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Deer's Head State Hospital Salisbury, Maryland</u>		DATE SIGNED <u>5/31/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>June 2, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>			

INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the local health department or to the nearest police station. It is not to be filled out for a person who has died of a violent or unnatural cause, or for a person who has died of a disease which is not reportable. It is not to be filled out for a person who has died of a disease which is not reportable. It is not to be filled out for a person who has died of a disease which is not reportable.

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BARTHOLOMEW, W. V.

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. MARITAL STATUS

10. EDUCATION

11. PREVIOUS ILLNESS

12. PREVIOUS SURGERY

13. PREVIOUS TRAUMA

14. PREVIOUS DRUGS

15. PREVIOUS ALCOHOL

16. PREVIOUS TOBACCO

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BUREAU V. 2

JUN 2 1955

RECEIVED

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

June 4, 1955

Bartholomew, W. V.

BARTHOLOMEW, W. V.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5105
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

051351

1. PLACE OF DEATH: <i>Wicomico</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Salisbury</i>	LENGTH OF STAY (in this place) <i>2 day</i>	CITY (If outside corporate limits write RURAL and give nearest town) <i>Green City Md</i>	<i>23 x - 2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>		STREET ADDRESS (If rural, give location) <i>✓</i>	
3. NAME OF DECEASED: (Type or Print) <i>George Henry Wainwright</i>		4. DATE OF DEATH (Month) <i>5</i> (Day) <i>28</i> (Year) <i>1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Dec 11 1913</i>
9. AGE last birthday: <i>41 1/2</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country): <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>John Wainwright</i>		14. MOTHER'S MAIDEN NAME: <i>Fannie Daines</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>9</i>	
17. INFORMANT & ADDRESS: <i>R.B. Wainwright Salisbury Md</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
981X Immediate cause (a) <i>Shotgun Wounds of Chest & Abdomen</i> DUE TO		<i>2 days</i>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <i>5-26-55</i>		19b. MAJOR FINDING OF OPERATION: <i>Lacerations of Liver and abdominal wall</i>	
20. AUTOPSY: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office, hotel, etc.) <i>Federal Island Sussex - Del.</i>	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>5 26 55 9 PM.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>Shot by Eddie Harvey Hills</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Earl H. Royer</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>5-29-55</i>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>May 30 1955</i>	
NAME OF CEMETERY OR CREMATORY: <i>Bethel</i>		LOCATION (City, town, or county) (State): <i>Worton Sussex Md</i>	
DATE REC'D BY LOCAL REG. <i>6-6-55</i>		24. FUNERAL DIRECTOR: <i>Watson & Gray Frensham Del</i>	
REGISTRAR'S SIGNATURE: <i>Mary W. Holloway</i>		ADDRESS	

RECEIVED

JUN 8 1955

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5127

CERTIFICATE OF DEATH

05126

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Panticoke</i>		LENGTH OF STAY (In this place) <i>Lifetime</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Panticoke</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED (Type or Print) <i>Bertie M. Wallace</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>May 19 19 55</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>4-8-1884</i>	9. AGE last birthday <i>71</i> yrs.	IF UNDER 1 YEAR Months <i>7</i> Days <i>3</i>	IF UNDER 24 HRS. Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Crown Home</i>		11. BIRTHPLACE (State or foreign country) <i>Panticoke, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frank Barclay</i>				14. MOTHER'S MAIDEN NAME <i>Anna Jones</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>4-970</i>		17. INFORMANT & ADDRESS <i>Julius Wallace, Panticoke, Maryland</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>						<i>12 Hours</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardiovascular</i>						<i>5 Years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>Renal Disease</i>							
STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 15 April 19 55 to 18 May 19 55, that I last saw the deceased alive on 18 May 19 55, and that death occurred at 6:10 PM, from the causes and on the date stated above.							
SIGNATURE <i>Richard H. Saunders M.D.</i>				ADDRESS (Street, city, town, state) <i>Panticoke Md.</i>		DATE SIGNED <i>5/19/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-22-55</i>		NAME OF CEMETERY OR CREMATORY <i>Panticoke Cemetery</i>		LOCATION (City, town, or county) <i>Panticoke, Maryland</i>	
24. REC'D BY REGISTRAR <i>May 23, 1955</i>		REGISTRAR'S SIGNATURE <i>Mary H. Hollaway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Cornelius H. Pasich</i>		ADDRESS <i>Baltimore, Maryland</i>	

CERTIFICATE OF DEATH

1953

Form 100-1

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. CAUSE OF DEATH	
5. PLACE OF BIRTH		6. DATE OF BIRTH	
7. SEX		8. RACE	
9. OCCUPATION		10. MARITAL STATUS	
11. PRESENT ADDRESS		12. DATE OF DEATH	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER	
17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF NOTARY		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF WITNESSES		22. SIGNATURE OF PHYSICIAN	
23. SIGNATURE OF CORONER		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF CLERK		26. SIGNATURE OF NOTARY	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF WITNESSES	
29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF CORONER	
31. SIGNATURE OF JUDGE		32. SIGNATURE OF CLERK	
33. SIGNATURE OF NOTARY		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF WITNESSES		36. SIGNATURE OF PHYSICIAN	
37. SIGNATURE OF CORONER		38. SIGNATURE OF JUDGE	
39. SIGNATURE OF CLERK		40. SIGNATURE OF NOTARY	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES	
43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF CORONER	
45. SIGNATURE OF JUDGE		46. SIGNATURE OF CLERK	
47. SIGNATURE OF NOTARY		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF WITNESSES		50. SIGNATURE OF PHYSICIAN	
51. SIGNATURE OF CORONER		52. SIGNATURE OF JUDGE	
53. SIGNATURE OF CLERK		54. SIGNATURE OF NOTARY	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESSES	
57. SIGNATURE OF PHYSICIAN		58. SIGNATURE OF CORONER	
59. SIGNATURE OF JUDGE		60. SIGNATURE OF CLERK	
61. SIGNATURE OF NOTARY		62. SIGNATURE OF DECEASED	
63. SIGNATURE OF WITNESSES		64. SIGNATURE OF PHYSICIAN	
65. SIGNATURE OF CORONER		66. SIGNATURE OF JUDGE	
67. SIGNATURE OF CLERK		68. SIGNATURE OF NOTARY	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESSES	
71. SIGNATURE OF PHYSICIAN		72. SIGNATURE OF CORONER	
73. SIGNATURE OF JUDGE		74. SIGNATURE OF CLERK	
75. SIGNATURE OF NOTARY		76. SIGNATURE OF DECEASED	
77. SIGNATURE OF WITNESSES		78. SIGNATURE OF PHYSICIAN	
79. SIGNATURE OF CORONER		80. SIGNATURE OF JUDGE	
81. SIGNATURE OF CLERK		82. SIGNATURE OF NOTARY	
83. SIGNATURE OF DECEASED		84. SIGNATURE OF WITNESSES	
85. SIGNATURE OF PHYSICIAN		86. SIGNATURE OF CORONER	
87. SIGNATURE OF JUDGE		88. SIGNATURE OF CLERK	
89. SIGNATURE OF NOTARY		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF WITNESSES		92. SIGNATURE OF PHYSICIAN	
93. SIGNATURE OF CORONER		94. SIGNATURE OF JUDGE	
95. SIGNATURE OF CLERK		96. SIGNATURE OF NOTARY	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESSES	
99. SIGNATURE OF PHYSICIAN		100. SIGNATURE OF CORONER	

BUREAU V. S.

MAY 23 1955

RECEIVED

21-017-2001240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5106 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05127
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Wicomico</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place) <u>6 hrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Pontotice</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Tolbert W. Wallace</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 30 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>1-27-33</u>
9. AGE last birthday: <u>22</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Clara, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Julius Wallace</u>		14. MOTHER'S MAIDEN NAME: <u>Maria Conway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>220-28-1568</u>	
17. INFORMANT & ADDRESS: <u>Julius Wallace, Pontotice, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Basilar Skull Fracture</u>			<u>6 hours</u>
Antecedent cause(s) (b) <u>Automobile Accident on Road</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Island Road</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>8/25X</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Highway</u>	21c. (City or town) (County) (State) <u>Queen Anne P.E.D. Somerset Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>May 30-55 5:30 P.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Automobile Accident</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>R. J. Johnson</u>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>6/3/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Pontotice Cemetery</u>	LOCATION (City, town, or county) (State): <u>Pontotice, Maryland</u>
DATE REC'D BY LOCAL REG: <u>6-1-55</u>	REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR: <u>Conelius H. Wessink, Beltsville, Maryland</u>	ADDRESS: <u>Beltsville, Maryland</u>

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO BE FILLED BY THE MEDICAL EXAMINER

NAME OF DECEASED	DATE OF DEATH	PLACE OF DEATH
AGE	SEX	RACE
EDUCATION	RELIGION	DATE OF BIRTH
DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH

1. NAME OF DECEASED	2. DATE OF DEATH	3. PLACE OF DEATH
4. AGE	5. SEX	6. RACE
7. EDUCATION	8. RELIGION	9. DATE OF BIRTH
10. DATE OF DEATH	11. PLACE OF DEATH	12. DATE OF BIRTH

13. NAME OF DECEASED	14. DATE OF DEATH	15. PLACE OF DEATH
16. AGE	17. SEX	18. RACE
19. EDUCATION	20. RELIGION	21. DATE OF BIRTH
22. DATE OF DEATH	23. PLACE OF DEATH	24. DATE OF BIRTH

25. NAME OF DECEASED	26. DATE OF DEATH	27. PLACE OF DEATH
28. AGE	29. SEX	30. RACE
31. EDUCATION	32. RELIGION	33. DATE OF BIRTH
34. DATE OF DEATH	35. PLACE OF DEATH	36. DATE OF BIRTH

37. NAME OF DECEASED	38. DATE OF DEATH	39. PLACE OF DEATH
40. AGE	41. SEX	42. RACE
43. EDUCATION	44. RELIGION	45. DATE OF BIRTH
46. DATE OF DEATH	47. PLACE OF DEATH	48. DATE OF BIRTH

49. NAME OF DECEASED	50. DATE OF DEATH	51. PLACE OF DEATH
52. AGE	53. SEX	54. RACE
55. EDUCATION	56. RELIGION	57. DATE OF BIRTH
58. DATE OF DEATH	59. PLACE OF DEATH	60. DATE OF BIRTH

61. NAME OF DECEASED	62. DATE OF DEATH	63. PLACE OF DEATH
64. AGE	65. SEX	66. RACE
67. EDUCATION	68. RELIGION	69. DATE OF BIRTH
70. DATE OF DEATH	71. PLACE OF DEATH	72. DATE OF BIRTH

73. NAME OF DECEASED	74. DATE OF DEATH	75. PLACE OF DEATH
76. AGE	77. SEX	78. RACE
79. EDUCATION	80. RELIGION	81. DATE OF BIRTH
82. DATE OF DEATH	83. PLACE OF DEATH	84. DATE OF BIRTH

BUREAU V. R.

JUN 3 1955

RECEIVED

OFFICIAL NON-PROFESSIONAL

ST. LOUIS, MO.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05128

5107

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 12 TOWN Salisbury		LENGTH OF STAY (in this place) 9 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Snow Hill Rd.,				STREET ADDRESS (If rural give location) 1 Snow Hill Rd.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ISAAC		(Middle) WALTER		(Last) WARE		DATE (Month) (Day) (Year) 5 14 19 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 5, 1891	9. AGE last birthday 63 (63) yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James R. Ware				14. MOTHER'S MAIDEN NAME Lotita Mc Clung			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) YES		16. SOCIAL SECURITY NO. W.W. I 218-16-8836		17. INFORMANT & ADDRESS Mrs. Bessie R. Ware		Same	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (CEREBRAL)			
162X IMMEDIATE CAUSE (A) METASTATIC BRONCHIOGENIC CARCINOMA				INTERVAL BETWEEN ONSET AND DEATH 3 wks.			
ANTECEDENT CAUSE(S) DUE TO (B) BRONCHIOGENIC CARCINOMA				4 mos.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) SCQUAMOUS CELL							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/26/1955 to 5/14/1955 , that I last saw the deceased alive on 5/14/1955 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
SIGNATURE Rufus S. Gardner, Jr.				ADDRESS (Street, city, town, state) M.D. 321 S. Division St., Salisbury, Md		DATE SIGNED 5/14/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland			
24. REC'D BY REGISTRAR DATE May 18, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Md.			

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TABLE 1

3.

1981, 2, 2055.

Exhibit

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A. E. U.

West Virginia

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245 on 4/25

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1993. 11 June 1993.

05-1-88

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BUREAU V. S.

MAY 18 1955

RECEIVED

The Hill & Johnson Co., Salisbury, Md.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5108

CERTIFICATE OF DEATH

05129

332

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL or and give nearest town) Salisbury		LENGTH OF STAY (in this place) All life		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 328 E. Church Street				STREET ADDRESS (If rural give location) 328 E. Church Street			
3. NAME OF DECEASED (Type or Print) Clarence Alexander Weste				4. DATE OF DEATH 5 - 3 - 19 55			
5. SEX Male		6. COLOR OR RACE A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH About 1885	
9. AGE last birthday About 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Salisbury, Wicomico Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Parsons		14. MOTHER'S MAIDEN NAME Jane Weste			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Salisbury, Md.			
18. MEDICAL CERTIFICATION		19. DATE OF OPERATION 0		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
IMMEDIATE CAUSE (A) Cerebral thrombosis		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 4/30/55		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis		22. I hereby certify that I attended the deceased from Feb , 19 55 , to 5-3 , 19 55 , that I last saw the deceased alive on 4/30 , 19 55 , and that death occurred at 12:30 PM, from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR May 6, 1955	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart		26. ADDRESS (Street, city, town, state) 324 E. Church St. Salisbury, Md.		DATE SIGNED 5/6/55	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		27. NAME OF CEMETERY OR CREMATORY Houston Cemetery		28. LOCATION (city, town, or county) (State) Salisbury, Wicomico Co. Md.			
29. DATE OF OPERATION		30. DATE THEREOF 5-6-55		31. REGISTRAR'S SIGNATURE Mary A. Holloway			

RECEIVED

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05130

Reg. Dist. No. 322

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>11 days</u>		TOWN <u>Marion Station</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS <u>--</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Mary</u>		(Middle) <u>Virginia</u>		(Last) <u>Whittington</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Jan. 23, 1869</u>	<u>86</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>None</u>			<u>--</u>		<u>Marion, Md.</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel T. Adams</u>				<u>Mary Ann Whittington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>--</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Acute myocardial insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>Indefinite</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis, generalized</u>						<u>"</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Auricular fibrillations</u>						<u>3 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 26, 1955</u> , to <u>May 7, 1955</u> , that I last saw the deceased alive on <u>May 7, 1955</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital Salisbury, Maryland</u>		DATE SIGNED <u>5/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		LOCATION (City, town, or county) (State) <u>Marion Station, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons-531 Main St.-Crisfield, Md.</u>		ADDRESS	
DATE <u>MAY 12 1955</u>							

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. OCCUPATION

9. CAUSE OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF CHURCH

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

BUREAU V. 4
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ENCLOSURE

INSTRUCTIONS
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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5110

05131

CERTIFICATE OF DEATH

Long, Briele & Fisher

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>12 SALISBURY</u>		<u>24 DAYS</u>		TOWN <u>MARDELLA SPRINGS</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>R.D. #</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>HARRY</u> (Middle) <u>THOMAS</u> (Last) <u>WILLEY</u>				(Month) <u>May</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 10, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>R.D. # Mardele Springs Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George W. Willey</u>				14. MOTHER'S MAIDEN NAME <u>Estelle (Unk)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS <u>Mrs. Mary Savage (Daughter) 1207 Vandiver Ave. Wilmington, Del.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
610X IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Benign prostatic hypertrophy</u>				<u>1 month</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>4-12-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Benign prostatic hypertrophy</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William H. Fisher, Jr.</u>				M.D. <u>N. Division St Salisbury, Maryland</u>			
DATE <u>5/3/55</u>				DATE SIGNED <u>May 2 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 4th, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mardele Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mardele, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

CERTIFICATE OF DEATH

5116

REG. DIST. NO.

LOCAL RESIDENT OR HOME OF DECEASED

PLACE OF DEATH

MARYLAND

COUNTY OF

DATE OF DEATH

DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF EXAMINATION

PLACE OF EXAMINATION

DATE OF SIGNATURE

PLACE OF SIGNATURE

DATE OF FILING

PLACE OF FILING

DATE OF CLOSURE

PLACE OF CLOSURE

DATE OF RE-ENTRY

PLACE OF RE-ENTRY

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

MAY 3 1955

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5111 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05132
Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 12 TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Salisbury</u> 12			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jersey Road</u>				STREET ADDRESS (If rural, give location) <u>103 E. Isabella St.</u>			
3. NAME OF DECEASED: (First) <u>John</u>		(Middle) <u>Walter</u>		(Last) <u>Williams</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>20</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2-9-1884</u>		9. AGE last birthday: <u>71</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Car salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Used cars.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles E. Williams</u>				14. MOTHER'S MAIDEN NAME: <u>Adeline Walker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>None Ruth L. Williams, Same</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
976X Immediate cause (a) <u>Shotgun wound of brain</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						Sudden	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>5-21-55</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Woods off Jersey Rd. Salisbury</u>		21c. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-20-55</u> <u>8A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Self inflicted 20 gauge shotgun wound brain</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>5-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary M. Holloway</u>		24. FUNERAL DIRECTOR <u>Willard Johnson & Sons, Inc.</u> <u>Hermant. Baker</u>			

BUREAU V. S.

MAY 25 1955

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5112

05133

CERTIFICATE OF DEATH

Dr. Mitchell

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN Salisbury		LENGTH OF STAY (in this place)		CITY OR TOWN Salisbury		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 313 Union Ave.				STREET ADDRESS 313 Union Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) WALLIS (Middle) JOSEPH (Last) WRIGHT				(Month) MAY (Day) 30 (Year) 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 6, 1899	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months 0 Days 24		Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Adjuster		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Newark, New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallis Wright				14. MOTHER'S MAIDEN NAME Julia A. EMMERY Farrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS Mrs. Velma L. Wright (Wife) 313 Union Ave			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) CEREBRO VASCULAR ACCIDENT				Salisbury, Maryland			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Cardio Vascular Disease -							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/9 , 19 53 , to 5/21 , 19 55 , that I last saw the deceased alive on 5/21 , 19 55 , and that death occurred at 10:30P AM, from the causes and on the date stated above.							
SIGNATURE Andrew C. Mitchell				ADDRESS (Street, city, town, state) 211 Maryland Ave. Salisbury, Md			
M.D. 211 Maryland Ave. Salisbury, Md				DATE SIGNED May 31 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 2, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE R. J. Daythe		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
DATE June 2, 1955							

CERTIFICATE OF DEATH

Dr. Mitchell

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311 Maryland Ave.

Telephone Company

June 2, 1953

Wife of

MARYLAND & COMPANY BALTIMORE, MARYLAND